Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Waiver Services:

A change to add another level of Respite Care service: Respite Care with Medication Administration. The change in respite services is accompanied by the addition of a higher rate to be paid to respite providers who meet the extra qualifications to administer medications. Currently, participants who require medication administration can only receive Respite Care services without medication administration.

PLANNED CHANGES:
Case Management as a Waiver Service: The Department plans to change from administrative case management to case management as a waiver service during FY 2012. The Department will submit a 1915b waiver to limit choice of case management providers. It is hoped that this change will allow for reduced case management caseloads in those Area Agencies on Aging serving the most participants. The plan at this time is to implement the 1915b waiver January 2012. A waiver amendment would also be submitted 90 days prior to this anticipated change to add case management as a waiver service.

Cost Neutrality: The Department also plans to make a change in the cost neutrality standard to allow a participant's plan of care to be approved up to 125% of the annual cost neutrality amount. This increase will address cost changes which will occur when administrative case management becomes a covered waiver service. Additionally, this change will ensure that participants who have increased needs can be served within the waiver program. The cost neutrality change will help to ensure that participant health, safety, and welfare needs continue to be met. This amendment to the waiver will be done in concert with implementation of the 1915b waiver.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Older Adults Renewal Waiver

C. **Type of Request: renewal**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who*

are dually eligible for Medicaid and Medicare.)

○ **3 years** ◉ **5 years**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0265

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 07/01/11

Waiver Number: MD.0265.R01.00

Draft ID: MD.22.01.00

Renewal Number: 01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

07/01/11

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- [ ] **§1915(b)(1) (mandated enrollment to managed care)**
- [ ] **§1915(b)(2) (central broker)**
- [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
- [ ] **§1915(b)(4) (selective contracting/limit number of providers)**

- [ ] **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose, Goals and Objectives

The purpose of the Waiver for Older Adults (WOA) is to provide community-based alternatives to institutional care for functionally impaired older adults in a cost effective manner. By offering a package of creative and flexible services, the waiver is able to serve older adults who meet a nursing facility (NF) level of care (LOC) in their own homes or in assisted living settings. Each participant has an individualized plan of care (POC) designed to support their health and safety while their care remains cost effective to Medicaid.

Organizational Structure

The Maryland Department of Health and Mental Hygiene (DHMH) is the single state Medicaid agency (SMA). DHMH's Office of Health Services (OHS) is responsible for ensuring compliance with federal and State laws and regulations relating to the operation of the waiver. Additionally, the SMA is responsible for policy development and oversight of the waiver, determining the participant's LOC, provider enrollment and compliance, reimbursement of covered services through MMIS, coordinating the fair hearing process, monitoring the performance of the operating state agency, and carrying out federal and state reporting functions.

The SMA has several other Medicaid divisions or programs integrally involved in the operation of the WOA. The Division of Eligibility Waiver Services (DEWS) performs functions related to the establishment of participant eligibility, including determining financial eligibility and notification to applicants or participants regarding full waiver eligibility, which is based on financial, technical and medical eligibility criteria. DHMH's Adult Evaluation and Review Services (AERS) is a statewide mandated program located within each local health department in Maryland. AERS staff, comprised of nurses and social workers, conduct comprehensive social and medical evaluations of waiver applicants initially and waiver participants when annual eligibility redeterminations are due. The

OHS Quality Care Review Team comprised of nurses and social workers annually review a statistically significant sample of WOA participants through in person inetrviews and record review at the area agency on aging. Finally, DHMH maintains a contract with a utilization control agent (UCA), whose function is to determine the LOC for applicants and participants.

The Maryland Department of Aging (MDoA) is the operating state agency (OSA)for the WOA. An inter-departmental Memorandum of Understanding (MOU) guides the responsibilities of the SMA and OSA in managing and administering the waiver. In turn, the OSA has a grant agreement with local Area Agencies on Aging (AAAs) to perform waiver case management (as an administrative service) and other administrative duties. Under the oversight and monitoring of the OSA, the AAAs are responsible for coordinating waiver applicants' application and enrollment; offering/documenting applicants/participants choice between institutional care and home and community-based services; choice among qualified providers; developing, approving and implementing participant POCs; and conducting quarterly site visits to monitor participant health, safety and satisfaction with services. In addition, the AAAs initiate annual waiver eligibility redeterminations, ensure annual POC reviews, and coordinate the denial and disenrollment process as appropriate. The SMA is responsible for receiving and reviewing Reportable Events (REs) and ensuring that there is timely and appropriate follow-up and resolution.

Service Delivery
The program offers the following services: assisted living services, assistive devices/equipment, behavioral consultation services, dietician/nutritionist services, environmental accessibility adaptations, environmental assessments, family/consumer training, home delivered meals, medical day care, personal care, personal emergency response systems (PERS), respite care, and senior center plus, and transition services. These services are rendered by self-employed and agency-employed workers, and assisted living service providers who must be approved and enrolled by Medicaid according to provider standards developed by DHMH or other State licensure requirements. All services must be authorized through the POC process and only those services that comply with the participant's POC will be reimbursed by Medicaid.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The SMA obtains ongoing public input into the development and operation of the Waiver for Older Adults in a variety of ways. The Medicaid Waiver for Older Adults Advisory Committee was established to provide an ongoing forum for stakeholders to provide input and guidance to SMA and OSA. The Advisory Committee is comprised of representatives the Legal Aide Bureau (a protection and advocacy organization), provider representatives from assisted living services and personal care services, representatives from area agencies on aging, and waiver participants and family members of waiver participants. The Committee discusses policy changes, proposed regulations, waiver amendments and renewals.

Regular updates about the Medicaid Waiver for Older Adults are also provided to the Maryland Medicaid Advisory Committee and the Urban Indian Organization.

When new or amended regulations or waiver applications/ amendments/renewals are proposed by the SMA, a notice is required to be published in the Maryland Register which includes notice on how copies of documents can be obtained. Additionally, draft versions of the applications will be posted on the DHMH website.

Regulations may not be promulgated until an opportunity for public comment is provided, including a response from SMA to all public comments received.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient

persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Wessely
First Name:	Jane
Title:	Chief, Division of Waiver Programs
Agency:	Department of Health and Mental Hygiene - Medical Care Programs
Address:	201 W. Preston Street
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-6765 **Ext:** ☐ **TTY**
Fax:	(410) 333-5213
E-mail:	wesselyj@dhmh.state.md.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Sraver
First Name:	Warren
Title:	Administrator, Medicaid Waiver for Older Adults
Agency:	Maryland Department on Aging
Address:	301 W. Preston Street, 10th Floor
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-1065 **Ext:** ☐ **TTY**
Fax:	(410) 333-5071
E-mail:	fws@ooa.state.md.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the

waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Jane Wessely
	State Medicaid Director or Designee
Submission Date:	Mar 31, 2011

Last Name:	Tucker
First Name:	Susan
Title:	Executive Director, Office of Health Services
Agency:	Department of Health and Mental Hygiene
Address:	201 W. Preston Street
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-1431
Fax:	(410) 333-5185
E-mail:	TuckerS@dhmh.state.md.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:
Maryland Department of Aging

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Department of Health and Mental Hygiene is the single state Medicaid agency charged with the administration of the Maryland's Medicaid Program (SMA). Medicaid's Office of Health Services (OHS) oversees the Medicaid Waiver for Older Adults (MWOA) through its Division of Waiver Programs. In this capacity, OHS oversees the performance of the Maryland Department of Aging, operating State agency (OSA) for the MWOA.
A Memorandum of Understanding (MOU) between the SMA and the OSA delegates to the OSA the primary operational duties of: oversight and monitoring of the case management function performed by the area agencies on aging (AAA) including annual monitoring visits to each AAA; training waiver staff of the AAAs; review of provider applications and certification of qualified providers to the SMA; new provider orientation; provider monitoring including on-going review of provider qualifications; claims review and processing prior to submission to MMIS; oversight of Reportable Event reporting and resolution; annual provider training; monitoring timeliness of eligibility determinations; monitoring timeliness of LOC determinations; issuing quarterly summary and analysis of Reportable Events to SMA and other required data reporting as described under the quality assurance and improvement sections of the renewal application.

The SMA is responsible for monitoring the OSA through:
1) Reviewing and updating the MOU annually by assessing each Departments' roles and responsibilities, particularly with regard to the OSA's delegated tasks 2) Reviewing quarterly mandated summary/analysis reports of Reportable Events submitted by the OSA to the SMA 3) Requiring attendance and participation by the OSA in the Waiver Quality Council which meets 3-4 times per year; 4) Ensuring monthly inter-agency coordination meetings are held bewteen the SMA and the OSA to discuss waiver policy and procedures,and operational issues 5) Ensuring quarterly planning

meetings in lieu of the inter-agency coordination meeting to review performance measures and remediation data, to identify the need for quality improvement activities or modification of the quality management strategy 6) Reviewing on an on-going basis the OSA's annual AAA monitoring reports and related corrective action 7) Reviewing all the OSA waiver policies, procedures and guidelines prior to their adoption 8)Utilizing the Quality Care Review Team (QCRT) to review individual participant plans of care which include health and safety needs. In addition, the team conducts reviews to assure participants are receiving care and services in accordance with their wishes, standards of prcatice, policies and regulation.

The assessment of the OSA's administrative and operational functions occurs on an on-going basis. The monthly inter-agency coordination meeting and the quarterly planning meeting are the regular forums for much of the SMA's assessment of the OSA's on-going performance as key data is presented along with analysis, remediation and plans for quality improvement.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Medicaid utilizes the services of a contracted Utilization Control Agent(UCA). The five-year contract was recently re-bid and the new contractor began work in February, 2011.

   The UCA conducts initial and annual determinations of level of care for the WOA.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   Non-state public agencies are:
   Prince George's County Dept. of Family Services – Aging Services Division
   Queen Anne's County Department on Aging
   St. Mary's Co. Office on Aging
   Anne Arundel County Depart. of Aging & Disabilities
   CARE Services, Baltimore City Health Department
   Baltimore Co. Dept. of Aging
   Calvert County Office on Aging
   Carroll County Bureau of Aging
   Senior Services and Community Transit of Cecil County
   Charles County Aging and Senior Programs
   Frederick Co. Dept. of Aging
   Harford Co. Office on Aging

Howard Co. Office on Aging
Montgomery Co. – Division of Aging and Disability Services

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

There are several AAAs that are non-profit agencies including two that operate as regional AAAs, each serving more than one jurisdiction. The grant agreement entered into with these AAAs is the same as the one entered into with the non-state public agencies.
The non-profit agencies are:
Allegany Co. Human Resources Development Commission, Inc.
Garrett County Area Agency on Aging
Upper Shore Aging, Inc. (serves Caroline Co., Kent Co. and Talbot Co.)
MAC, Inc. (serves Dorchester Co., Somerset Co., Wicomico Co., and Worcester Co.)
The Washington County Commission on Aging, Inc.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
1.The Office of Health Services (OHS) contracts with a UCA to perform level of care (LOC) determinations. The Deputy Director of Medicaid Long Term Care Financing supervises the Chief of the Division of Long Term Care (DLTC), who is the contract monitor for the UCA contract. On a quarterly basis, DLTC staff performs budget reconciliation of the UCA's review performance statistics. There are monthly sample reviews of the appropriateness of Medicaid LOC determinations by the UCA, which include waivers. Additionally, a sample (which includes waivers) of LOC determinations are reviewed monthly by DLTC staff for timeliness according to contract standards. Additionally, OHS employs two physicains who review decisions as needed including all denials of LOC that reult in appeal by participnats.

2. The OSA is responsible for assessing the performance of the AAA in accordance with the grant agreement between both entities. This is accomplished through regularly scheduled meetings, traing, technical assistance and annual formal on-site monitoring. The SMA monitors AAA performance in its annual Quality Care Review Team (QCRT) Team retrospective reviews of participant records. The AAA is provided with a report by the QCR Team at the end of the review that identifies areas in which the AAA should improve its operations and corrective action plans may be required by the OSA.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
1. Utilization Control Agent

The SMA uses a number of methods to assess the performance of
of the UCA contracted to conduct LOC determinations. The Division of Long Term Care (DLTC)is chiefly responsible for performance assessment.

The UCA sends monthly statistical reports to the DLTC which are used by the DLTC for the on-going review of the UCA for timeliness and appropriateness of LOC determinations. There are regularly scheduled conference calls (generally daily or weekly during the transition phase but at least monthly) with the UCA to discuss operational issues or problem cases. The SMA clinical staff consisting of physicians and nurses are available on an on-going daily basis to consult with the UCA as needed for policy clarification as well as individual case consultations. Additionally, the SMA clinical staff will review all LOC determinations that result in appeals by participants.

If the DLTC review indicates ongoing, systematic problems in LOC decision-making, Medicaid will pursue a series of corrective actions including designating clinical staff to review cases in dispute and identify areas where training may be required, and conducting training for the UCA as indicated. Medicaid will increase the level of Departmental involvement in the decision-making process before issuing LOC determination notices to recipients if training and technical assistance fail to improve the UCA's performance. If these efforts fail to improve performance, the Department will pursue financial sanctions against the UCA and ultimately, as a last resort, terminate the UCA's contract.

2. Area Agencies on Aging

The OSA conducts annual on-site reviews of each AAA to assess their compliance with COMAR, the terms of the Waiver Grant Agreements and other program directives. This entails a review of participant and administrative records, as well as other documentation related to AAA assigned duties. The OSA is closely involved with addressing with the AAAs, findings of the annual review of WOA participants and the AAAs by DHMH's Quality Care Review Team (QCRT).

The QCRT identifies a statistically relevant sample of waiver participants that will be the focus of their review based on the county in which participants reside. The QCRT reviews the participant record maintained by the AAA and completes an in-person survey of the participant. Specific attention is paid to whether or not services are being provided as authorized on the participant's POC, required quarterly case manager visits are being conducted and whether the identified needs and choices of the individual are being adequately addressed. The findings of these reviews are summarized in a report. When necessary, a Corrective Action Plan (CAP) may be requested from the AAA to address the findings on a particular participant or an overall shortcoming in how the AAA is carrying out their responsibilities. A CAP may also be required from a provider for issues reported by the participant, the case manager or issues identified in the records.

The second phase of the annual AAA review is conducted by the OSA. The OSA focuses its review on the same sample of waiver participants reviewed by the QCRT. The OSA reviews participant files and AAA records for related documentation. These reviews are conducted approximately 6 months after the QCRT reviews to facilitate follow-up on the QCRT findings and, as appropriate, the AAA's progress in operationalizing the details of their CAP.

The OSA's review also includes a comparison of claims and payment records to the POC to confirm that only authorized services are being provided and billed for by appropriate, qualified providers. The AAA is given a report following these reviews that summarizes the findings. Standardized forms are used by the QCRT and the OSA. Findings are scored and entered into a database for analysis, tracking and trending.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐	☐
Waiver enrollment managed against approved limits	☑	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☑	☐	☐
Level of care evaluation	☑	☐	☑	☐
Review of Participant service plans	☑	☑	☐	☑
Prior authorization of waiver services	☑	☑	☐	☑
Utilization management	☑	☑	☐	☐
Qualified provider enrollment	☑	☑	☐	☐
Execution of Medicaid provider agreements				

	☑	☐	☐	☐
Establishment of a statewide rate methodology	☑	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☐	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1 Delegated Task: Rules, Policies, Procedures and Information Development Governing the Waiver Program No.& percent of waiver policies & procedures developed by OSA approved by SMA prior to their adoption/implementation. N = # of waiver policies & procedures approved by SMA prior to adoption/implementation by OSA D = # of waiver policies, procedures & guidelines adopted/implemented by OSA

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2 Delegated Task: Quality Assurance and Quality Improvement Activities No. and percent of Reportable Events (REs) that were appropriately resolved by the OSA within 45 calender days of OSA receiving the RE report in accordance with Maryland's Reportable Events policy. N = # of REs appropriately resolved by OSA within 45 days D = # of REs received by OSA

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM3 Delegated Task: Qualified Provider Enrollment No. and percent of provider applications certified by the OSA as meeting all waiver requirements as verified by SMA. N = # of OSA certified provider applications as verified by SMA. D = # of provider applications certified by OSA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Application review by SMA.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM4 Delegated Task: Waiver Enrollment Managed Against Approved Limits Number and percent of unduplicated participants for whom the OSA's designees (AAAs)have issued Authorization To Participate forms (ATP) to SMA that remain less than or equal to the number of slots available. N= # of unduplicated participants for whom ATPs are issued D= # of approved slots available.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Older Adults Waiver Tracking system

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM5 Waiver Services Managed Against Approved Levels.Number and percent of claims paid that were in accordance with participants' approved plan of care. N= # of claims in accordance with the reviewed participants' plans of care, D = # of participant records reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Ad hoc data report from the SMA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM6 Delegated Task: Utilization Management Number and percent of environmental accessibility adaptations (EAA)exceeding lifetime cap that are authorized by OSA. N= # of EAA projects approved by OSA to exceed life time cap D= # of EAA projects that exceed life time cap

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA generated report to OSA

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = Describe Group:
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM7 Delegated Task: Prior Authorization of Waiver Services Number and percent of POCs authorized by OSA's designee prior to the implementation of services. N= # of POCs authorized D= # of POCs reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM8 Delegated Task: Review of Participant Service Plans Number and percent of findings of non-compliance for service plans addressing health and safety risk factors appropriately and timely remediated by OSA. N= # of non-compliance findings appropriately and timely remediated by OSA D= # of non-compliance findings by OSA

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval

		= 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM9 Delegated Task: Level of Care Evaluation Number and percent of LOC determinations, both initial and annual redeterminations,completed by UCA contractor within 28 days. N = # of determinations completed timely D = # of determinations completed

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative**

		Sample Confidence Interval = [ ]
☑ **Other** Specify: Utilization Control Agent contractor	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% random sample of all LOC determin-ations for OAW
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: [ ]	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: [ ]

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
PM3 The SMA program specialist for the OAW reviews the applications forwarded to the SMA by the OSA to ensure that the provider is qualified to enter into a Medicaid Provider Agreement with the SMA and receive a Medicaid provider number.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
PM1 The MOU between the OSA and the SMA requires the OSA to submit all policies & waiver guidance to the SMA for review before they are issued/implemented. If a policy or other guidance is distributed prior to the SMA

review, the SMA will review the material to determine if the SMA is in agreement. If the SMA decides that revision is necessary, the policy will be revised by the SMA and re-issued by the OSA. The original effective date will remain as is unless it is not feasible due to the nature of the SMA revisions.
If revision is not necessary, the SMA will send the OSA a written reminder of necessity to adhere to the MOU as it relates to this performance measure. Further non-compliance will be remediated through the CAP process.

PM2 Failure of the OSA to adequately resolve REs within 45 days will be remediated through the CAP process. On an individual RE level, the SMA will require the SMA to document the reason that each RE has not been resolved in a timely manner as well as specific plans and timeline for resolution. Repeated instances of non-compliance will be addressed in a meeting between upper management staff of the SMA and OSA with agreed upon actions planned to achieve compliance.

PM3 The OSA submits completed provider applications to the SMA certifying that the provider meets all requirements of the waiver. If the SMA staff find missing information, incorrect or outdated credentials, the application is returned to the OSA for correction. Problems regarding this process are discussed at inter-agency coordination meetings and solutions are reviewed. Failure by the OSA to consistently, correctly certify provider applications would result in training for the OSA staff by the SMA. Additional problems with the certifcation process will result in the request for a CAP to be submitted by the OSA to the SMA.

PM4 The OSA reviews the number of approved participants via the WOA Tracking System as well as the number of available slots on a monthly basis and submits the data to the SMA on a quarterly basis. If enrollment comes to wthin 200 slots of the Factor C, the report from the OSA must be submitted monthly. When enrollment is within 50 slots of Factor C, the OSA and the SMA will consult weekly to ensure the OSA's designees (AAAs) do not issue ATP's in excess of Factor C.
If the SMA fails to send quarterly or monthly reports of approved applicants and available slots, the first incident would be remediated through the CAP process. Further instances of non-compliance will be addressed in a meeting between upper management staff of the SMA and the OSA with agreed upon actions planned to achieve compliance.

PM5 The SMA will initiate a recovery of funds for services provided that are not in accordance with the participant's approved plan of care. Technical assistance is provided to the provider by the OSA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.

PM6 Environmental Acessibility Adaptations (EAA) have a lifetime benefit cost cap in the WOA. Waiver program policy allows for projects to exceed the life time benefit cap established for the EAA service with pre-approval by the OSA if there are very special participant circumstances that need to be addressed to ensure health and safety.
Failure by the OSA to pre-approve each EAA project whose cost exceeds the participant's life time benefit cap, whether by itself or in addition to EAAs previously received by the participant, will result in the SMA requirement for a CAP from the OSA. Repetitive non-compliance may result in the pre-approval responsibility being shifted from the OSA to the SMA.

PM9 The contract with the UCA requires that 95% of LOC determinations be completed within 28 days. If the data review finds that the UCA has completed less than 95% of the cases within the required time frame of 28 days, the Contract Monitor will inform the UCA and request explanatory information on each determination that was not timely. There are a number of external factors that may affect the timeliness of a determination such as a late response to a request for more information or clarification by the UCA. If the contractor is responsible for the lack of timeliness corrective action will be taken. Corrective will include, but is not limited to, requiring the implementation of a correction plan or retracting payment from the UCA if non-compliance continues after a corrective action plan has been put in place.

If the review finds that the UCA has completed less than 95 percent of the cases within the required time frame, the Contract Monitor will inform the UCA and request explanatory information on each determination that was not timely. If the contractor is responsible for the lack of timeliness corrective action will be taken. Corrective will include, but is not limited to, requiring the implementation of a correction plan or retracting payment from the UCA if non-compliance is high and/or repetitive.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	50	64	
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐

	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Individuals may stay in the waiver under the Aged target subgroup.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

A comprehensive evaluation by AERS staff is the first method of determining that an applicant's health and welfare can be assured within the cost limit in advance of waiver enrollment. The AERS assessment is given to the WOA case manager and is used in the development of the waiver POC. The POC will incorporate all waiver and state plan services necessary to safely maintain the participant in the community. The case manager is responsible for costing out the services included on the POC as

part of this process. The POC will be reviewed by the multidisciplinary team, which includes the applicant and his/her representative, as appropriate. If the POC exceeds the cost neutrality cap, the team will explore ways with the applicant/rep to possibly reduce services while maintaining health and safety. This may, for example, entail arranging for more informal supports and reducing personal care service hours, reducing days of attendance at adult medical day care, etc. only if the health and safety of the participant will not be compromised. . As stated, POC development is based upon a comprehensive assessment by the multidisciplinary team. A final POC would not be approved if the multidisciplinary team made the determination that reducing any service would deprive an individual of necessary care and could have a detrimental impact on the individual's health and safety.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

All opportunities to revise the POC will be explored if a participant can no longer be served in a cost effective manner. For instance, if adding personal care hours pushes costs over the cost neutrality limit because the participant is less able to care for themselves, the use of assisted living services can be explored. Or perhaps the use of medical day care for 6 hours a day could reduce the number of hours of personal care with medication administration that are needed or the extra monthly hours of nurse monitoring.

In the event there is no solution available, the case manager will develop a discharge plan with the participant and representative/s. There may be another waiver that has more flexibility in the individual cost neutrality standard and if so, a referral would be made. Other actions may include referring the participant to AERS to provide detailed assistance in identifying non-waiver community resources and other support services. In addition, the waiver case manager may also refer the participant to the Information and Assistance service (I&A) at the local AAA. I&A staff also have expertise in identifying community resources and can provide certain financial benefit information if a participant is losing Medicaid eligibility as well. The Medicaid unit of the local department of social services is also a typical referral source when there are issues of Medicaid eligibility or planning needs to begin for financing long term care placement in a nursing facility. In some cases it is clearly evident that nursing facility placement is appropriate and acceptable to the participant and the case manager will provide guidance in how to locate a nursing facility in their community.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3750
Year 2	3750
Year 3	3750
Year 4	3750

Year 5	3750

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3200
Year 2	3200
Year 3	3200
Year 4	3200
Year 5	3200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Eligible individuals are enrolled in the waiver program on a first-come, first-served basis until the annual cap on the unduplicated number of participants or the maximum number of participants (see table B-3-b) on waiver participation is reached. This policy is established in WOA program regulations, COMAR 10.09.54.
A Waiver Services Registry was established a number of years ago for individuals who are interested in receiving waiver services when openings become available. Individuals call a toll-free number and add their name and contact information to the Registry. When waiver slots become available due to attrition or an increase in the annual cap of enrollees, DHMH notifies the staff at the Registry to mail waiver applications by the order in which individuals have placed their names on the Registry.

Additionally, in accordance with Maryland's Money Follows the Individual Act, an individual residing in a nursing facility whose care for 30 days is eligible to be covered by Medicaid long term care may apply at any time to the WOA. Maryland also participates in the Money Follows the Person (MFP)demonstration program. Individuals residing in nursing facilities who qualify for MFP may also apply to the WOA at any time.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (•) **100% of the Federal poverty level (FPL)**

- **% of FPL, which is lower than 100% of FPL.**

  Specify percentage:

- **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- **Medically needy in 209(b) States (42 CFR §435.330)**
- **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  1. Individuals ineligible for AFDC/TCA due to requirements that do not apply under Title XIX.(42 CFR §435.113

  2. Individuals who meet the income and resource requirements of the cash assistance programs(42 CFR §435.210)

  3. Optional Coverage of the medically needy (42 CFR §435.301 Subpart D).

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - **A special income level equal to:**

      Select one:

      - **300% of the SSI Federal Benefit Rate (FBR)**
      - **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage:

      - **A dollar amount which is lower than 300%.**

        Specify dollar amount:

    - **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI**

program (42 CFR §435.121)

- [x] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- ◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ◉ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  Select one:

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    Specify:
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:

  300% of the SSI Federal Benefit Rate (FBR) for persons living at home Institutionalized personal needs allowance + $420 room and board monthly for persons residing in assisted living facilities.
- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.
  - **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:
- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42

§CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

The State will exclude expenses older than three months prior to the month of application.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

  Specify formula:

  300% of the SSI Federal Benefit Rate (FBR) for persons living at home institutionalized personal needs allowance + $420 room and board monthly for persons residing in Assisted Living Facilities.
- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

The current Utilization Control Agency(UCA)is the Delmarva Foundation for Medical Care, Inc.(DFMC) DFMC was awarded a 3-three year contract with the SMA which began February 2011.

- **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The SMA contracts with a UCA that is a Quality Improvement Organization to determine a waiver applicant's level of care (LOC). The UCA employs licensed registered nurses to certify nursing facility LOC and a physician, as does the SMA, who will assist in the determination of LOC when there are unusually complex or contested decisions. All LOC determinations are subject to review and approval by the SMA.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Applicants and participants in the WOA are required to have a nursing facility level of care. The same medical eligibility standard is applied to waiver participants as it is to individuals seeking approval for institutional nursing facility services. Applicants for waiver services are assessed for functional status - ADL's & IADL's, behavioral issues, and cognitive status in order to determine their need for health-related services that are above the level of room and board(42CFR 440.155).

The UCA uses the SMA's standardized LOC evaluation tool titled the "DHMH 3871B" to assess each applicant for a nursing facility level of care as well as to conduct annual LOC redeterminations.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The process begins with DHMH's Adult Evaluation and Review Services (AERS) conducting a comprehensive assessment of the applicant using standardized form DHMH 3871B. AERS forwards all supporting medical documentation to the UCA. The UCA reviews and scores the DHMH 3871B to determine if an applicant meets the level of care. Additional information is sought by the UCA if there is insufficient information to make a final determination. This information may come from the applicant/participant's family, physician or a discharging facility such as a hospital or nursing facility.

If the scored DHMH 3871B fails to meet the threshold score established for NF eligibility, it is reviewed by registered nurses and/or a physician to make the final determination.

For annual reevaluations the DHMH 3871B is completed by the AERS and forwarded to the UCA for recertification of medical eligibility.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The OSA has implemented a report that regularly identifies delays in LOC redeterminations. The OSA contacts the AAA when LOC redetermination delays are identified and reviews details of the OSA's delay report with the AAA. The AAA is required to report back to their assigned the OSA program specialist within 7 business days on actions taken or being taken to ensure the redeterminations are processed within the required timeline of every 12 months so that the redetermination process is completed before the LOC expires.

In the event the UCA did not complete a LOC determination, the AAA would investigate the reason for the lack of a LOC with the UCA, and any difficulties with the UCA's performance would be referred to the SMA's contract monitor for the UCA contract.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Maryland Medicaid regulations which govern all Medicaid providers require that providers must maintain adequate records for a minimum of six years, and make them available, upon request, to the Department or its designee.

UCA is contractually required to maintain records for a minimum of six years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new participants who received a LOC before initiation of service.
N= The number of new participants who received a LOC before initiation of service, D= Total number of new waiver participants.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants receiving an annual LOC redetermination within 12 months of the most recent LOC. N= Number of participants receiving an annual LOC determination within 12 months of most recent LOC, D= Number of participants due for annual LOC determination.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☑ **100% Review**

Agency		
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

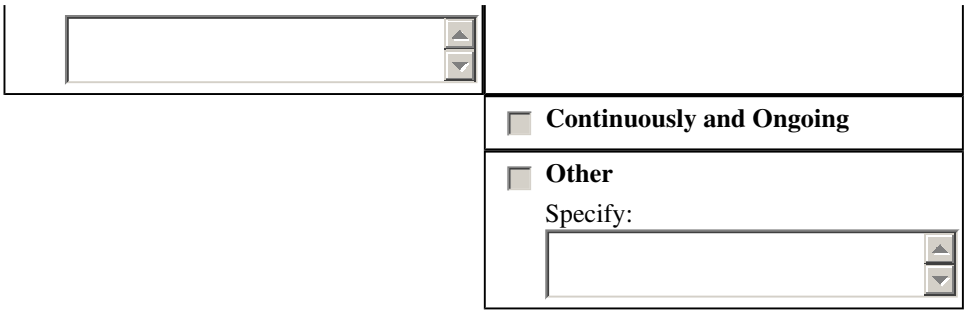
Performance Measure:
Number and percent of participant LOC determinations completed using the approved LOC form. N=Number of participant LOC determinations completed using the approved LOC form, D= Number of participant LOC determinations completed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**



ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The WOA tracking system links all parties that have a role in determining and redetermining the participant's elgibility: Adult Evaluation and Review Services (SMA), Office of Health Services (SMA), the OSA and AAAs, UCA, Division of Eligibility Waiver Services (DEWS - SMA). Information regarding the initial and annual LOC redeterminations is in the system allowing all parties to be aware of the stage of LOC processing and due dates for annual redeterminations.
The operating agency reviews the Application Status and Redetermination Status Reports within 10 business days of each month to determine if there were any delays in the prior month that needed to be flagged to the Area Agencies on Aging (AAA). On a quarterly basis within a fiscal year, the operating agency conducts a retroactive review of the Application Status and Redetermination status Reports to review delayed applications as follows:
i)prior three months of the 1st quarter,
ii)prior six months of the 2nd quarter,
iii)prior nine months of the 3rd quarter,
iv)prior 12 months of the fiscal year end.
The AAA is responsible for documenting in the Case Notes Section of the Tracking System all contacts and actions made with entities responsible for the delays in application determination and redetermination process to ensure timely LOC determinations.
The OSA conducts an annual review of a representative sample of LOC determinations. In the event use of an unapproved LOC tool was found, the OSA would notify the SMA UCA contract monitor. The UCA would be requested to immediately assess participant's LOC using the approved tool.
The SMA's Quality Care Review Team conducts an annual random review of participants served in the WOA. The QCRT also looks for the presence of the approved LOC tool in participant records.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The OSA will contact the AAA when LOC determinations or redetermination delays are identified. The OSA reviews details of the delay report with the AAA. The AAA is required to report back to their assigned the OSA program specialist within 7 business days on actions taken or being taken to ensure the applications are processed within the timeline required by federal regulations, and the redetermination process is completed before the LOC expires.

In the event the UCA did not complete a LOC determination, the AAA case manager would see this in the tracking system. The AAA would investigate the reason for the lack of a LOC with the UCA. The LOC determination would again be requested and any difficulties with the UCA's performance would be referred to the SMA's contract monitor for the UCA contract. The SMA's eligibility staff will look for the LOC in the tracking system before a notice of waiver eligibility is sent out.
During the OSA's annual sample participant file review, the OSA reviews the LOC tool used in LOC determinations. In the event use of an unapproved LOC tool was found, the OSA would notify the SMA UCA contract monitor. The UCA would be requested to immediately assess participant's LOC using the approved tool. Should the participant not meet NF LOC, the participant would be disenrolled and assisted to identify other services.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The AAA assigns a case manager to meet with each applicant to discuss the services available through the waiver, and begins to develop a plan of care. The participant is provided with a welcome packet that includes a freedom of choice form called the Participant Consent Form. The form explains the individual's right to choose between institutional and community-based services in a Medicaid waiver. The form also explains that the individual has the right to choose among all enrolled WOA providers. The individual or representative is required to sign the freedom of choice form. The individual or representative also signs a form acknowledging receipt of the welcome packet information.

The application is not considered complete, nor will the applicant be enrolled in the waiver program until the Participant Consent Form is signed by the applicant or his/her chosen representative.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for Medicaid services. Methods of enabling access include providing interpreters at no cost to the individual, and translations of forms and documents. Statewide foreign language interpretation/translation services are available through a state-wide contract to Maryland State agencies (as well as Maryland's other non-State government entities such as the local governments, counties, municipalities, etc.) to facilitate continuously available language translation services to minimize or eliminate any language barrier.

Interpreter resources are available for individuals who contact the SMA or the OSA for information, to request assistance or to file complaints. Several AAAs have hired bilingual staff due to the large number of non or limited English speaking participants accessing waiver services. It has also been observed that a number of providers speak other languages in addition to English which is of great assistance to participants and their families. Participants with LEP are encouraged to recommend individuals they know who are fluent in their language to enroll as their personal care providers.

The DHMH website contains useful information on Medicaid waivers and many other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if requested. If an appellant with LEP attends a Medicaid hearing without first requesting the services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings without benefit of an interpreter. If not, the hearing will be postponed until the services of an interpreter have been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Adult Medical Day care
Statutory Service	Personal Care
Statutory Service	Respite
Other Service	Assisted Living
Other Service	Assistive Devices and Equipment
Other Service	Behavior Consultation Services
Other Service	Dietitian/Nutritionist Services
Other Service	Environmental Accessibility Adaptations
Other Service	Environmental Assessments
Other Service	Family/consumer Training
Other Service	Home-Deliverd Meals
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Senior Center Plus
Other Service	Transition Services

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):
Adult Medical Day care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Medical Day Care is a program of medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living.

A. Medical Day Care includes the following services:
(1) Health care services supervised by the director, medical director, or health director, which emphasize primary prevention, early diagnosis and treatment, rehabilitation and continuity of care.
(2) Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse.
(3) Physical therapy services, performed by or under supervision of a licensed physical therapist.
(4) Occupational therapy services, performed by an occupational therapist.
(5) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene.
(6) Nutrition services.
(7) Social work services performed by a licensed, certified social worker or licensed social work associate.
(8) Activity Programs.
(9) Transportation Services.

B. The Program will reimburse for a day of care when this care is:
(1) Ordered by a participant's physician semi-annually;
(2) Medically necessary;
(3) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
(4) Provided to participants certified by the Department as requiring nursing facility care under the Program as specified in COMAR 10.09.10;
(5) Provided to participants certified present at the medical day care center a minimum of 4 hours a day by an adequately maintained and documented participant register; and
(6) Specified in the participant's service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A Waiver participant must attend the MDC a minimum of 4 hours per day for the service to be coverable. The frequency of attendance is determined by the participants' case manager and is part of the plan of care developed by the multi-disciplinary team. The waiver participants cannot attend day habilitation or supported employment on the same day as MDC.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Medical Day Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Medical Day care

Provider Category:
Agency
Provider Type:
Adult Medical Day Care
Provider Qualifications
License *(specify):*
Must be licensed by OHCQ
Certificate *(specify):*

Other Standard *(specify):*
Providers must meet the requirements of COMAR 10.09.07 for medical Day Care Waiver providers.
Verification of Provider Qualifications
Entity Responsible for Verification:
SMA is responsible for the verification of adult medical day care providrs.
Frequency of Verification:
At enrollment and ongoing

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Personal Care
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal care services, both with and without delegated nursing functions, include a range of assistance that enables the waiver participant to accomplish tasks they are unable to perform independently. This assistance is usually related to activities of daily living and instrumental activities of daily living. When specified in the participant's POC, personal care services may also include assistance with housekeeping chores such as bed making, dusting and vacuuming. These services must be incidental to the personal care furnished and essential to the health and welfare of the individual, rather

than the individual's family. Personal care providers must meet State standards for this service. Also included is instruction to the participant related to self-care.

Personal care that entails performing delegated nursing functions such as assistance with self-administration of medications or administration of medications by the aide are covered if the service is provided by an appropriately trained aide under the supervision of a licensed registered nurse, in accordance with Maryland's Nurse Practice Act, COMAR 10.27.11 Delegation of Nursing Functions.

A registered nurse evaluates the participant and instructs/trains the personal care aide to assist the participant with maximizing independent performance of activities of daily living. Personal care providers may be members of the individual's family, with the exception of a spouse.
Personal Care Nurse Monitoring:
A registered nurse, licensed to practice nursing in the State of Maryland, supervises all personal care aides. The nurse monitor supervises the participant's medical condition and the care rendered by the personal care aide, by reviewing the participant's POC, interactions and relationship between the participant and personal care aide, and the personal care aide's performance and ability to render the required services. The nurse is required to complete a home visit monthly and monitor the participant's medical condition and need for personal care services. Personal care services under the state plan differ in service definition and provider type from the personal care services offered under the WOA.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal care services may be provided on either an on-going routine basis or a short-term basis. Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual. Payment will not be made for services furnished to a participant by that individual's spouse.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Agency
Individual	Individual Personal Care Aide

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Personal Care Agency
Provider Qualifications
License *(specify):*
Residential Service Agency License for skilled Nursing and aides.
Certificate *(specify):*
All personal care aides must have current First Aide and CPR certificates. If performing Nurse Delegated tasks should be a Certified Nursing Assistant (CNA)and Certified Medicine Technician (CMT) or be Certified Medicine Aide (CMA)
Other Standard *(specify):*
The personal care aide must be at least 18 years old, can be the participants relative except the participant's

spouse, must be able to speak, read, write, and follow directions in English, submit to a criminal background investigation, may not have been convicted of, received a probation before judgment for, or entered a plea of nolo contendere to a felony or any crime involving moral turpitude or theft, or have any other criminal history that indicates behavior which is potentially harmful to participants.
May not be cited on the Maryland Geriatric Nursing Assistants Registry or any other registries with a determination of abuse, misappropriation of resident property, or neglect.
Before providing service, the personal care provider must be evaluated by a nurse monitor employed by a nurse provider agency.

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualification.

Frequency of Verification:
At Enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual

Provider Type:
Individual Personal Care Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*
All personal care aides must have current first aide and CPR. If performinfg Delegated Nursing services should be a certified Nursing Assistant (CNA)and certified Medicin Technician (CMT) or be a ecrtified Medicine Aide (CMA)

Other Standard *(specify):*
All personal care services must be provided in accordance with the participants plan of care.
Prior to initiation of services:All aides providing care to waiver participants should have a clean criminal back ground check report; and the personal care aide must be evaluated and determined by the personal care nurse monitor to understand and able to carry out personal care services and accept instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:
MDoA

Frequency of Verification:
At enrollment and ongoing

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite care is provided on a short-term basis to relieve those care givers who normally provide the participant's care. Respite care may be provided in an individual's residence, Medicaid-certified nursing facility or other community care residential facility approved by the State. Overnight respite care may be delivered in an assisted living or nursing facility. Not included are nursing services or delegated nursing functions performed by a trained aide under the nurse's supervision, i.e. medication assistance or administration.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
At Home Respite Care is limited to no more than 12 hours of respite care per date of service because individuals will receive daily personal care according to their POC in addition to respite care services for the remaining hours as required to meet their needs. Over 12 calendar months, respite care is limited to no more than 168 hours. This 12- month period will begin on the date the initial provider renders the client's first service.Out of Home Respite Care is limited to no more than 14 days of respite care in a nursing facility and/or assisted living facility for a waiver participant over 12 calendar months. Out-of- home respite care is only covered for overnight stays.
Effective July 1, 2011 the respite care reimbursement rates will change to specify respite care with medication admininstration and respite care without medication administration. The rate for respite care with medication administration will be higher due to higher participant care needs and additional qualification requirements for the respite aide.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Service Agency
Agency	Assisted Living
Agency	Nursing Facility
Individual	Individual respite provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Residential Service Agency
Provider Qualifications

License *(specify):*
OHCQ Residential Service license.
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as a program provider of Home health services under COMAR 10.09.04, personal care services in accordance with COMAR 10.09.20.03.

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Assisted Living
Provider Qualifications

License *(specify):*
OHCQ Assisted living license for level 2 or level 3.
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as a program provider of assisted living. Must have appropriate facilities for overnight care.

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications

License *(specify):*
OHCQ nursing facility license.
Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a program provider for respite services only. Nursing facility services under COMAR 10.07.02, approved by DHMH.
Must have appropriate facilities for overnight care

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is reponsible for verification of provider qualifications.

Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Individual respite provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Have a current First Aide and CPR certificate. When admininstering medication the aide must be a certified medicine aide(CMA) or certified medication technician (CMT) and a cartified nursing asistant(CNA).

Other Standard *(specify):*
The aide must be an individual personal care aide and must have the same qualification as the individual personal care services standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.

Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Assisted Living

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assisted Living is a residential program that provides housing and supportive services for individuals who need assistance in performing activities of daily living, such as eating, toileting, dressing and if needed, medication management. The assisted living manager is required to provide, arrange or facilitate access to the services listed below for all residents including waiver participants. Changes in a waiver participant's physical, functional or psychosocial behaviors or abilities must be reported to the case manager, delegating registered nurse and as appropriate, the participant's physician. These individuals work as a team to ensure that the participant receives necessary services. When the ALM, case manager, physician, or delegating registered nurse determine that a participant is in need of a service such as home health or skilled nursing services, the ALM is responsible for arranging for that service while ensuring participant choice of providers and transportation for the participant. The ALM may seek guidance in making these service arrangements from the case manager, delegating nurse or the participant's physician. Often these types of services require physician orders as a condition of Medicaid or Medicare reimbursement.

Medicaid reimburses the majority of services for this waiver population as fee for service for waiver services and State Plan services. However, waiver participants who are not dually eligible and under age 65 receive their non-waiver medical care through managed care organizations (MCOs). Service providers bill and are paid by Medicaid or the MCO directly. The participant's case manager is responsible to follow-up if there are any issues with access to services. The services listed below are available to participants regardless of level of care needed at the assisted living facility since categories of services are not tied to level of care, but rather scope and intensity.
Services:
1. 3 meals per day and snacks –
   a. provision of or arrangement for special diets
   b. 4-week menu cycle approved by a licensed dietitian or nutritionist at the time of licensure approval and licensure renewal
2. Daily monitoring of resident & resident's assisted living service plan
   a. 24-hr supervision
   b. one staff person per 8 participants on duty during day time hours
   c. Resident care notes initially on admission and at least weekly thereafter to reflect any significant changes in resident's condition.
3. Personal care and chore services including:
   a. assisting with activities of daily living, including instrumental activities of daily living
   b. routine housekeeping, laundry, and chore services
4. Medication management – including administration of medications or regular assessment of participants ability to self-medicate, regular oversight by the facilities delegating nurse, and on-site pharmacy review for residents with 9 or more medications every six months.
5. Facilitating access to health care and social services, including but not limited to:
   a. social work services
   b. rehabilitation services (occupational, physical, speech and therapies)
   c. home health services
   d. hospice services
   e. skilled nursing services
   f. physician services
   g. oral health care
   h. dietary consultation and services
   i. counseling
   j. psychiatric
   k. other specialty health and social work services
   l. providing or arranging for socialization opportunities, leisure activities and access to religious and spiritual activities including providing/arranging transportation
6. Nursing supervision and delegation of nursing tasks by registered nurse
7. Basic personal hygiene supplies
8. Assistance with transportation to Medicaid and other needed services

Assisted living facilities are licensed to provide up to three levels of care. The level of care determinations for assisted living residents are made based on a scoring tool that was developed for the State's assisted living program. While there is no direct correlation between the assisted living scoring instrument and the scoring instrument for nursing facility level of care there are many commonalities. Both tools require assessments based on functional, cognitive, behavioral and medical information. The assessment tool used for nursing facility level of care also reviews the need for extensive skilled services such as, tracheotomy care, complex respiratory services and ventilator care, which is not relevant to assisted living care. In addition, the assessment tools inclide specific questions which assist in determining the need for awake

overnight staffing and for on-site nursing.

First and foremost, all OAW participants must be assessed by the UCA as requiring a nursing facility level of care to be eligible to participate in the waiver. When participants chose to live in assisted living facilities, they are also assessed for one of three levels of assisted living care. Level 1 care is for residents requiring minimal assistance, Level 2 care provides moderate assistance and Level 3 provides intensive services, particularly supervision. Assisted living facilities in Maryland are licensed to provide certain levels of care based upon the manager's specialized education and experience, staffing patterns, staff training, degree of coverage by a registered nurse/s, and presence of awake overnight staff. The OAW reimburses only Level 2 or 3 assisted living services as these levels of service are consistent with the needs of individuals with a NF LOC.
The definitions for Level 2 and 3 assisted living care are as follows:
Level 2: Moderate Level of Care
(a) An assisted living program that accepts a resident who requires a moderate level of care shall have staff with the abilities to provide the services listed in (b)—(g) and the program shall provide those services.
(b) Health and Wellness. Staff shall have the ability to:
(i) Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition; and
(ii)Provide or ensure access to necessary health services and interventions.
(c) Functional. Staff shall have the ability to provide or ensure substantial support with some, but not all, activities of daily living or minimal support with any number of activities of daily living.
(d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication, or to administer necessary medication and treatment, including monitoring the effects of the medication and treatment.
(e) Behavioral. Staff shall have the ability to monitor and provide or ensure intervention to manage frequent behaviors which are likely to disrupt or harm the resident or others.
(f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage frequent psychological or psychiatric episodes that may require limited skilled interpretation, or prompt intervention or support.
(g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing assistance in accessing social and recreational services.

Level 3: High Level of Care
(a) An assisted living program that accepts a resident who requires a high level of care shall have staff with the abilities to provide the services listed in (b)—(g) of this and the program shall provide those services.
(b) Health and Wellness. Staff shall have the ability to:
(i)Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the residents' condition; and
(ii)Provide or ensure ongoing access to and coordination of comprehensive health services and interventions including nursing overview.
(c) Functional. Staff shall have the ability to provide or ensure comprehensive support as frequently as needed to compensate for any number of activities of daily living deficits.
(d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication, and to administer necessary medication and treatment, including monitoring or arranging for monitoring of the effects of complex medication and treatment regimens.
(e) Behavioral. Staff shall have the ability to monitor and provide or ensure ongoing therapeutic intervention or intensive supervision to manage chronic behaviors which are likely to disrupt or harm the resident or others.
(f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage a variety of psychological or psychiatric episodes involving active symptoms, condition changes, or significant risks that may require skilled interpretation or immediate interventions.
(g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing access to comprehensive social and recreational services.

To assure that home-like setting is maintained in larger settings, COMAR 10.07.14 which governs the licensure of assisted living facilities (ALFs) contains a number of regulatory provisions that require attention given to providing a home and community character in the ALF regardless of the resident capacity.
These include:
-choice of roommate, whenever possible
-right to share room with spouse who also resides there unless medically contraindicated
-right to determine dress and wear own clothing, hairstyle and other personal effects
-requirement of space for recreational activities
-requirement for a living room that can be used by residents at any time
-requirement for outside activity space

-limitation of no more than two residents per bedroom, with partitions provided if requested
-requirements for certain types of home-like furnishings to be provided if residents have not brought their own
-requirement for at least one private, common-use telephone to be provided at no cost
-right for resident to meet or visit privately with guests that the resident has invited

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The provider bills Medicaid for Level 2 without medical day care, level 2 with medical day care, Level 3 without medical day care, or level 3 with medical day care assisted living services according to the participant's assessed level of assisted living care and medical day care attendance. The Medicaid assisted living service daily waiver reimbursement rates for level 2 with/without medical day care and level 3 with/without medical day care cover all of the required services listed above including the referral to medical and social services.

The ALF must be licensed to provide the level of care for which they are billing and level of assisted living care must be authorized for each participant in his/her POC. The Level 3 waiver reimbursement rates are higher than level 2 waiver reimbursement rates because of the enhanced responsibilities of the ALF in providing care to participants with more complex needs. Level of waiver reimbursments are also higher on non day care days when the waiver participant remains at the assisted living facility for all their services for that day. The daily reimbursement amount will be prorated for any days that the waiver participant was not eligible or did not reside at the facility. Room and board is not included in the monthly reimbursement rate paid to the assisted living providers by Medicaid. The participant is responsible for the cost of room and board, for which the provider may charge a maximum of $420/month.

Medical day care providers must provide participants a minimum of four hours of services per date of service in order to be reimbursed by Medicaid. Quite a few medical day care centers also transport participants to and from medical appointments. Medical day care services that are duplicative of ALF services include the medical day care center's provision of meals/snacks (up to 2 meals a day) and special diets, social and recreational activities, nursing oversight of medications and health care status by a registered nurse, assistance with activities of daily living such as grooming , bathing, eating, and medication management. Medical day care has the capability, however, to provide skilled nursing services which is not the case in ALF's unless home health or hospice are brought in for this purpose.

The waiver ALF reimbursement rate does not cover the following services that are through the State Plan benefits or the participant's MCO:
a. social work services
b. rehabilitation services (occupational, pgysical, speech and therapies)
c. home health services
d. hospice services
e.skilled nursing services
f. physician services
g. oral health care
h. dietary consultation and services
i. counseling
j. psychiatric
k. other specialty health and social work services
l. providing or arranging for socialization opportunities, leisure activities and access to religious and spiritual activities including providing/arranging transportation.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Assisted Living Facility
Provider Qualifications
License *(specify):*
OHCQ Assisted Living Facility License Level 2 or 3.
Certificate *(specify):*
The aides should have first aide certificates and always have enough aides with CPR certificate on duty. Should be a certified Medication Technician if Admininstering Medicatin. The delegating nurse should be registered nurse.
Other Standard *(specify):*
The assisted living manager and alternate manager compelet all their training courses.
Verification of Provider Qualifications
Entity Responsible for Verification:
MDoA verifies the provider qualifications
Frequency of Verification:
At enrollment and ongoing

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Devices and Equipment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assistive devices and equipment are medical or non-medical devices or appliances that are necessary to facilitate a participant's independence in performing activities of daily living. Such devices or equipment include but are not limited to, extenders to assist with reaching and dressing, special eating instruments, door alarms, shower seats, geriatric chairs, bed-rails, and egg-crate mattresses.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistive devices and equipment are only covered if the item serves to prevent the participant's institutionalization or hospitalization, and ensures the participant's health and safety. Assistive devices and equipment are not to be prescribed primarily to provide comfort or convenience. Assistive devices and equipment may not include eyeglasses, hearing aids, or dentures.

The WOA will only cover the cost of an assistive device and equipment if it is not covered under the state plan as durable medical equipment or pharmacy services, Medicare or any third party payer as part of another service such as, home health, or outpatient services. Devices and equipment must be preauthorized by the AAA Case Manager and approved in the participant's POC. The cost of assistive devices and equipment may not exceed $1000 per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Devices and Equipment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Devices and Equipment

Provider Category:
Agency
Provider Type:
Assistive Devices and Equipment
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The provider must be Medicaid State Plan provider of Disposable Medical Supplies/Durable Medical Equipment (DMS/DME)to apply for enrollment as an Assistive Devices and Equipment under the older adults waiver..

Verification of Provider Qualifications
Entity Responsible for Verification:
OSA
Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavior Consultation Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Behavior consultation services are provided in a participant's home or the assisted living facility to assist the caregiver/s in understanding and managing a participant's problematic behavior. The provider performs an assessment of the situation, determines the contributing factors, and recommends interventions and possible treatments. The provider prepares a written report which includes the assessment and the provider's recommendations which are discussed with the waiver case manager, the assisted living providers, or family. The appropriate course of action is determined and the provider may also recommend resources such as medical services available to the participant under the State plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A qualified individual provides services during a home or assisted living facility visit to a participant. Claims are paid in hourly increments, however, time spent in related activities such as preparation or documentation before/after the home visit or the provider's time spent on any supervisory or consultative services are not compensable. Behavior consultation services must be preauthorized in a participant's POC in order to qualify for reimbursement under the WOA.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Services Agency
Individual	Registered nurse, Psychologist, Clinical social worker, Psychiatrist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Consultation Services

Provider Category:
Agency
Provider Type:
Health Services Agency
Provider Qualifications
License *(specify):*
Office of Health Care Quality.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible to verify the provider qualifications.

Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Consultation Services

Provider Category:
Individual

Provider Type:
Registered nurse, Psychologist, Clinical social worker, Psychiatrist

Provider Qualifications

License *(specify):*
Licensed by professional boards.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible to verify the provider qualifications.

Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Dietitian/Nutritionist Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Dietitian and nutritionist services include individualized nutrition care planning, nutrition assessment, dietetic instruction and assistance with meal planning. The service is provided when the participant's condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian to assess participants and assist them and their caregivers with a plan to optimize nutritional outcomes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dietitian and nutritionist services are not available to individuals in assisted living and may not include services rendered on a group basis or in a classroom setting or provided to participants residing in an assisted living facility. The services shall target the individualized needs of the participant, rather than being of general interest. The provider must be sensitive to the educational background, culture, religion, eating habits and preferences, and general environment of the participant, and specified in the participant's waiver plan of care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional group or agency which employs licensed staff
Individual	Dietitian or Nutritionist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietitian/Nutritionist Services

Provider Category:
Agency
Provider Type:
Professional group or agency which employs licensed staff
Provider Qualifications
License *(specify):*
The employed staff must be licensed in accordance with COMAR 10.56.01 Board of Dietetic Practice, and Health Occupations.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietitian/Nutritionist Services

Provider Category:
Individual

Provider Type:
Dietitian or Nutritionist

Provider Qualifications

License *(specify):*
Be licensed in accordance with COMAR 10.56.01 Board of Dietetic Practice and Health Occupations .

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.

Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Environmental accessibility adaptations are physical modifications to the home (not assisted living facilities) designed to support the participant's efforts to function with greater independence and/or to create a safer, healthier environment. Adaptations may include the cost, installation and maintenance of ramps, grab bars/ handrails, stair glides, widening of doorways, and modifications of a bathroom or kitchen facilities. Locks, buzzers or other devices on a door to prevent or stop a cognitively impaired participant from wandering may also be covered. Environmental accessibility adaptations must be preauthorized in the participant's POC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excluded are those adaptations or improvements to the home, such as carpeting, roof repair, and central air conditioning, which are of general utility and are not of direct medical or remedial benefit to the participant. All construction shall be provided in accordance with applicable state or local buildings codes and pass the required inspections. Any adaptation must be preauthorized by the case manager and approved in the participant's plan of care. Additionally, if the participant is leasing the property, all adaptations must be approved by the owner of the home or building, who agrees that the participant will be allowed to remain in the residence at least one year.

If an adaptation is estimated to cost over $500, the case manager shall obtain at least two bids for the service. Environmental accessibility adaptations are limited to $5000 per participant in a calendar year and capped at

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Accessibility Adaptations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*
Licensed contractor in state of Maryland

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Maryland Department of Aging

Frequency of Verification:
annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Assessments

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

An environmental assessment is an on-site assessment of the physical plant of an assisted living facility, home, or other residence where the participant lives to determine if environmental adaptations/modifications or assistive devices/equipment may be necessary to safeguard the safety of the participant. Included in the environmental assessment is an evaluation of the present and likely progression of the participant's disability or chronic condition, environmental factors in the facility or home, and the participant's ability to perform activities of daily living, strength, range of motion, and endurance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The provider will complete a report for the case manager's review that documents findings and recommendations based on an inspection of the facility/home and interviews with the staff/family, delegating nurse/nurse monitor and participant. The report will detail the provider's findings and specify the assistive equipment, durable medical equipment, assistive devices that may be needed by the participant.

If an applicant plans to reside in an assisted living facility, this expert assessment will assist the case manager to arrange the best match possible between the applicant and an assisted living facility if the applicant has special needs. If modifications are needed beyond basic handicapped accessibility, the assisted living provider can decide if they are able to accommodate and pay for these adaptations. If not, a more appropriate facility will be located.

If an environmental assessment is conducted for a participant already residing in an assisted living facility due to progression of a chronic condition or due to a new condition such as a stroke, the assisted living facility will be expected to provide and pay for basic accessibility adaptations. However, if another facility is more physically accommodating, the participant would have the option of re-locating. This intervention may possibly prevent unnecessary re-institutionalization.

Medicaid will pay the environmental assessment provider the lesser of $381.46 per unit of service or the provider's usual and customary charge to the general public, reduced by any payments made by Medicare or another insurer. The service must be rendered by a licensed occupational therapist. To be covered as a waiver service, Medicaid, Medicare, or other third party health insurance under fee-for-service or managed care, must not otherwise cover the environmental assessment by an occupational therapist. In Maryland, those programs offering occupational therapy to adults, such as home health, are for provision of direct therapy. If Medicare covers the environmental assessment for the waiver participant, Medicaid will pay the Medicare co-payments or deductible.

An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational therapist
Agency	Agency employing a licensed occupational therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessments

Provider Category:
Individual
Provider Type:
Occupational therapist
Provider Qualifications
License *(specify):*
Licensed by the Board of Occupational Therapy as a licensed Occupational therapist.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessments

Provider Category:
Agency
Provider Type:
Agency employing a licensed occupational therapist
Provider Qualifications
License *(specify):*
Employed staff must be Licensed by the Board of Occupational Therapy.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family/consumer Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Training and counseling services are available as needed for the waiver participant or family member. For this service, "family" is defined as the person/s who live with or provide care to a waiver participant, and may include a parent, spouse, children, relatives, foster family, in-laws, or other unpaid "informal" caregivers. Family does not include individuals who are employed to care for the participant. Training may include such topics as how to hire, train, and supervise personal care and other waiver providers. Instruction may also be provided about treatment regimens, dementia, and use of equipment specified in the POC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is provided on a one-on-one basis during a home or office visit with the participant or family member. The training targets the individualized needs of the participant, rather than providing information that is of general interest. Training must be designed to be sensitive to the educational background, culture, religion, and environment of the participant. The unit of service is one hour and providers may only bill for the length of the visit, not for related activities performed before or after the visit. The training may not be rendered on a group basis or in a classroom setting, or provided to a participant or the family member of a participant who resides in an assisted living facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nurse, Occupational therapist, Physical therapist, Social worker
Agency	Assisted Living, Home Health agency under COMAR 10.09.04; Personal care nurse case monitoring agency such as local health department; Residential service agency, congregate housing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/consumer Training

Provider Category:
Individual
Provider Type:
Nurse, Occupational therapist, Physical therapist, Social worker
Provider Qualifications
License *(specify):*
Licensed by professional board for nursing, occupational therapy, physical therapy, social work.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/consumer Training

Provider Category:
Agency
Provider Type:
Assisted Living, Home Health agency under COMAR 10.09.04; Personal care nurse case monitoring agency such as local health department; Residential service agency, congregate housing.
Provider Qualifications
License *(specify):*
Certificate *(specify):*
DHMH certified as RSA.
MDoA certified as a congregate housing services.
Certified as a Medicare outpatient rehabilitation program.
Other Standard *(specify):*
Appropriate experience to render training.
Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible to verify provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Deliverd Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home-delivered meal services provide for no more than two meals delivered to a waiver participant's home per day. Each meal shall be nutritionally adequate based on the Recommended Dietary Allowance (RDA) Dietary Reference Intake (DRI) for persons aged 51 or older, as established by the Food and Nutrition Board of the National Research Council. The meal shall meet one of the following criteria: (1) therapeutic or restrictive diet requirements ordered by the participant's physician or by a waiver provider of dietitian/nutritionist services; or (2) at least1/3 of the RDA/DRI. The meals may be hot, cold, frozen, or shelf-stable, as recommended by the waiver multidisciplinary team, which includes the participant or by a waiver provider of dietitian/nutritionist services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Meals are available only for participants living at home. This service may not constitute the individual's full nutritional regimen of three meals per day.

Reimbursement under the waiver for a home-delivered meal must be considered as payment in full, and may not supplement or be supplemented by payment from other sources (participant, family, local government, private agency). The WOA will pay for at most two meals per day for a participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agencies on aging, qualified food vendors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Deliverd Meals

Provider Category:

Agency

Provider Type:

Area Agencies on aging, qualified food vendors

Provider Qualifications

License *(specify):*

Food service license by the local health department in accordance with COMAR 10.15.03, or by the licensing authority in the state in which the site is located

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

OSA is responsible for verification of provider qualifications.

Frequency of Verification:

At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device or system which enables waiver participants to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The PERS is connected to the participant’s phone and is programmed to call the provider’s response center if the “help” button is activated

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision. The provider must be the store, vendor, organization, or company, which sells, rents, installs, services, or runs the device or service. The provider must be able to provide any installation, servicing, training, or monitoring required for the device or system. The response center must be staffed by trained professionals 24 hours a day, 7 days a week.

Medicaid payment is capped at $1,000 per participant for the purchase and installation of equipment, and a $45 per month for monitoring/maintenance of equipment.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Store, vendor, organization, or company, which sells, rents, installs, services or runs the device or service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency
Provider Type:
Store, vendor, organization, or company, which sells, rents, installs, services or runs the device or service
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The provider must be able to provide any installation, servicing, training, or monitoring required for the device or system. The provider must assure that any response center is adequately staffed 24 hours a day by appropriately trained staff.

Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Senior Center Plus

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Senior Center Plus is a program of structured group activities and enhanced socialization provided for four or more hours a day on a regularly scheduled basis. The program is designed to facilitate the participant's optimal functioning and to have a positive impact on the participant's orientation and cognitive ability.

Senior Center Plus is provided for one or more days per week, in an outpatient setting, most often within a senior center. Services available in a Senior Center Plus program include social and recreational activities designed for elderly/disabled individuals, supervised care, assistance with activities of daily living and instrumental activities of daily living and enhanced socialization, as well as one nutritional meal. Health services are not included, therefore, Senior Center Plus is an intermediate option between senior centers and medical day care/adult day care which is available under the State plan.

Some providers of Senior Center Plus elect to provide transportation even though it is not required. If a Senior Center Plus program does not offer transportation, the waiver participant can request transportation from the Medicaid Transportation Program, which also provides transport to medical appointments for all Medicaid recipients.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Provides services to participants at least 4 hours a day, 1 or more days a week on a regularly scheduled basis, in an out- of -home setting. At least one meal a day is served and snacks are served when the day program exceeds 6 hours.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Center Plus

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Senior Center Plus

Provider Category:
Agency
Provider Type:
Senior Center Plus
Provider Qualifications
License *(specify):*
Employ as the center's manager or in another position an individual who is a licensed health care professional or licensed social work.
Certificate *(specify):*
MDoA certified as a senior center plus provider.
Other Standard *(specify):*
Be approved by MDoA as a nutrition service provider
Employee or manager who is a licensed health professional or licensed social worker, has at least 3 years experience in direct patient care in an adult day care center, nursing facility, or health-related facility, is literate and able to communicate in English, and participates in training specified and approved by the

Maryland Department of Aging.
Provide at least one staff person per eight clients, or additional staffing if required by MDoA.
Have menus reviewed and approved quarterly by a licensed dietition for nutritional adequacy.

Verification of Provider Qualifications

Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.

Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution or a private provider-operated living arrangement to their own private residence where the individual is directly responsible for his or her living expenses. The goal of the service is to enable the individual to set up a basic household when the individual lacks the resources to bear the expense and other resources are not available. Allowable expenses that do not constitute room and board, may include the following:
1) Security deposits to obtain a lease on an apartment or home
2) Essential furnishings and moving expenses
3) Set-up fees for access and deposits for utility services
4) Services necessary for the individual's health and safety such as pest eradication
5) Necessary home environmental adaptations
Transition services must be reasonable and necessary as determined through the plan of care process and may not include rental or mortgage expenses, regular utility costs, food and/or items used for solely recreational purposes. Transition services must be identified in the plan of care and provided by a qualified, enrolled provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
a.Transition funds for eligible participants may not exceed $3000.
b.Transition services may not extend beyond sixty (60) days after a participant has transitioned.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition services provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Services

Provider Category:
Agency
Provider Type:
Transition services provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet the requirements of COMAR 10.09.54 Older Adult Waiver Program
Verification of Provider Qualifications
Entity Responsible for Verification:
OSA is responsible for verification of provider qualifications.
Frequency of Verification:
At enrollment and ongoing.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The OSA's designees, the area agencies on aging, conduct the case management function under the oversight of the OSA and SMA.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Agency and independent personal care providers.
(b) The scope of the investigations are State of Maryland only.
(c) The OSA receives criminal background reports for self-employed personal care aides directly from the Criminal Justice Information System (CJIS) Office of the Maryland Department of Corrections and Public Safety. When a personal care agency enrolls in the waiver program, the OSA reviews all employee requirements including the criminal background check. For ongoing monitoring, personal care agencies are required to submit a monthly employee list with a signed attestation by the employer that all of the employees listed have met all qualifications and certifications necessary for meeting WOA provider standards in accordance with program regulations. An acceptable criminal background report from CJIS is a key component of provider qualifications for personal care providers. If agency providers do not submit the monthly employee list, payment will be withheld.
In addition, the OSA conducts desk audits and on-site audits of the personal care agency providers. These audits include checking and reviewing CJIS reports for employees.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted living facilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

COMAR 10.07.14 which governs the licensure of assisted living facilities (ALFs) contains a number of regulatory provisions that require attention given to providing a home and community character in the ALF regardless of the resident capacity.
These include:
-choice of roommate, whenever possible
-right to share room with spouse who also resides there unless medically contraindicated
-right to determine dress and wear own clothing, hairstyle and other personal effects
-requirement of space for recreational activities
-requirement for a living room that can be used by residents at any time
-requirement for outside activity space
-limitation of no more than two residents per bedroom, with partitions provided if requested
-requirements for certain types of home-like furnishings to be provided if residents have not brought their own
-requirement for at least one private, common-use telephone to be provided at no cost
-right for resident to meet or visit privately with guests that the resident has invited

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted living facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Dietitian/Nutritionist Services	☐
Family/consumer Training	☐
Senior Center Plus	☐
Respite	☑
Behavior Consultation Services	☐
Environmental Assessments	☐
Transition Services	☐
Adult Medical Day care	☐

Environmental Accessibility Adaptations	☐
Personal Care	☐
Assistive Devices and Equipment	☐
Assisted Living	☑
Home-Deliverd Meals	☐
Personal Emergency Response Systems (PERS)	☐

Facility Capacity Limit:

N/A

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide service. Controls: Relatives/legal guardians are treated no differently than other approved waiver providers. A service provided by a relative/legal guardian is subject to the same plan of care and claims monitoring procedures that are required of all waiver providers.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1:#and % of new providers requiring licensure and/or certification that are determined by the OSA to meet the required licensure and certification standards prior to enrollment. N= #of new providers requiring licensure and/or certification approved by OSA to meet required standards prior to enrollment, D= # of new providers requiring licensure and/or certification approved by SMA for enrollment.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of active providers required to be licensed and/or certified who continually meet the required licensing standard. N= Number of active providers who meet required licensing and/or certification standards, D= Number of active providers required to meet licensing and/or certification standards.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1: # and percent of new non-licensed/non-certified independent personal care providers who are approved by OSA to meet the waiver requirements prior to the initiation of services. N= Number of OSA approved non-licensed/non-certified independent personal care providers, D= # of new non-licensed/non-certified providers approved by SMA for enrollment to provide independent personal care services.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of active non-licensed/non-certified independent personal care providers who continually meet the waiver requirements. N= number of active independent personal care providers who continually meet the waiver requirements, D= number of active independent personal care providers.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1: Number and percent of new personal care agency and assisted living providers that meet State training requirement for attending the provider orientation. N=Number of new personal care agency and assisted living providers who attended the provider orientation. D= Number of new personal care agencies and assisted living providers enrolled.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of active assisted living providers who meet state training requirements. N= Number of active assisted living providers who attended provider training sessions, D= Number of active enrolled assisted living providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Providers must meet State licensure and waiver requirements in order to participate in the Waiver for Older Adults. The OSA and the SMA agencies verify all providers' licensure and certificates at the time of enrollment and conduct provider orientation trainings for personal care agencies and assisted living providers before certifying them for enrollment in the program.

The OSA will review provider licensure data on a monthlty basis to identify providers in need of licensure renewal within the next two months of the report.

All personal care agencies serving Waiver participants are required to submit a complete monthly employee report of listing of all current employees serving waiver clients by the first and no later than the 10th of each month. The agencies attest under the penalty of purjury that the aides included on the list are qualified and meet the licensing and certification requirements.

The OSA conducts desk and on-site audits of approved providers to verify that providers continually meet the licensure and certification requirements.

The OSA requires all new personal care and assisted living providers to attend a provider orientation as part of their provider enrollment process. Only the applications of the providers who attended the orientation are finalized and submitted to the SMA for final approval.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
All provider applicants identified by the OSA as not meeting the licensure requirements receive a letter which specifies the required licensure and the due date. The provider's application is only approved when the provider submits all the required licensure to the OSA.
In order for the OSA to assure personal care agency's compliance with PC aide licensure and certification requirements, the OSA on the 11th of each month sends a letter to all non-compliant personal care agencies who failed to submit their monthly employee list. The letter explains that any claims submitted for reimbursement by the non-compliant provider will be not be paid until compliance is demonstrated. The letter also informs the providers that failure to submit their monthly employee list will result in their disenrollment from the waiver program.

When deficiencies are identified as part of provider audits, the OSA provides the agency with a list of identified deficiencies including the list of unqualified staff that agency may not allow to serve waiver clients. The OSA meets with the providers to discuss the issues and assists the provider to become compliant with the requirements. If needed, the OSA requires the providers to attend the orientation training to review program requirements. The OSA continiues monitoring the agency until either they become compliant with the requirements or are disenrolled from the program. The OSA and the SMA withhold provider claims and recover payments as necessary.

Any identified unlicensed provider is disenrolled from the program.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and

welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☑ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Required to have a license, degree, or certification as a health professional or to have at least 2 years of experience in a human services program for the elderly or closely related population.

☑ **Social Worker.**

Specify qualifications:

Required to have a degree, license, or certification as a social worker.

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The following safeguards are in place:
1. Any POC that lists an AAA as a service provider must be reviewed and approved by the OSA.
2. The case manager, by regulation and grant agreement, is required to review the POC as necessary or at least quarterly to determine the appropriateness and adequacy of the services. This means all services regardless of who the provider is, AAA or otherwise.
3. The OSA, as a part of its annual AAA audit, reviews a sample of participant records to ensure proper procedures are followed in the development of the POC which includes: reviewing recommendations for waiver and non-waiver services identified by AERS, confirming that at least one waiver service is listed, an adequate back up plan is in place, service type, frequency and duration is identified, required signatures are obtained, supervisor review and approval is completed, as well as review of case notes, quarterly review reports, nurse monitoring reports, and reportable events to make certain that the POC reflects any care issues that are identified in these documents.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The case manager provides participant and/or authorized representative with the list of services and enrolled providers and includes them as part of the multidisciplinary team that is responsible for developing the POC as required by waiver regulations. The participant and/or authorized representative may request that other individuals be included in the process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The process for developing a waiver Plan of Care (POC) consist of the following steps to ensure that the services in the POC

will protect a participant's health, safety, and welfare; and to reflect the participant's choice of waiver services:

a) The development of the POC involves a multi-disciplinary team that includes the following individuals: case manager, participant and/or authorized representative, nurse, and social worker. The participant and/or authorized representative may request that other individuals be included in the process as well. The POC development process is initiated by the case manager when the Adult Evaluation Review Services (AERS) assessment is completed, and the LOC has been obtained.

b) AERS nurses and social workers conduct a comprehensive evaluation to determine the participant's medical diagnosis, social, functional, and cognitive/behavioral status. AERS then develops a recommended POC based on the comprehensive evaluation which addresses behavioral, nutritional and environmental needs, and specifies waiver and non-waiver services, that includes the units and frequency of the recommended services. The AERS recommended POC is forwarded to the AAA case manager who then reviews the AERS recommendations with the participant and/or authorized representative, and discusses their preferences and goals.

c) The case manager meets with the participant and/or authorized representative to review the waiver and non-waiver services that were recommended by AERS, and provides the participant with a brochure that list all of the waiver and Medicaid services available.

d) In addition to discussing with the participant and/or authorized representative the recommendations made by AERS that addresses the participant's health needs, the participant and/or authorized representative is given the opportunity to discuss their own needs as well. The participant's needs and preferences are reflected in the selection of services and choice of providers listed in the POC, and they're required to sign the POC as evidence of their approval and participation in the development of the POC.

e) Waiver and non-waiver services are coordinated by the waiver case manager based on the needs and preferences of the participant, as well as the recommendations made by AERS to address the participant's health needs. Should the waiver participant need services that are not covered by Medicaid, the waiver case manager will make referrals to other state or local agencies, community advocacy groups, civic and religious organizations.

f) The waiver case manager is responsible for developing the POC with the other members of the multi-disciplinary team, coordinating all services, submitting the POC to their supervisor for review and approval before it can be implemented,and providing a copy of the approved POC to providers listed on the POC. The OSA is responsible for monitoring the POC development which includes: reviewing recommendations for waiver and non-waiver services identified by AERS, confirming that at least one waiver service is listed, an adequate back up plan is in place, service type, frequency and duration is identified, required signatures are obtained, supervisor review and approval is completed. Additionally, the OSA reviews case notes, quarterly review reports, nurse monitoring reports, and reportable events to make certain that the POC reflects any care issues that are identified in these documents.

g) The case manager is responsible for revising the POC as needed if the participant's health status and/or environment have changed; or at least reviewing the POC for appropriateness, and revising it as needed on a quarterly basis when the waiver case manager visits with the participant in the their home or ALF. The waiver case manager is required to update the POC annually as part of the annual medical redetermination process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The following describes how potential risks to the participant are assessed during POC development process:

a) The Adult Evaluation Review Services (AERS) performs a medical and comprehensive assessment when an individual initially applies for the program, annually when redetermining waiver medical eligibility; or as needed based on changes in a participant's health and/or environment.

b) The AERS assessment must take place at the individual's residence, which allows the assessor to evaluate the risk factors associated with the individual's health, and also those associated with the current care environment.

c) Information regarding the individual's medical diagnosis, their social, functional and cognitive/behavioral status is recorded on the AERS assessment form and an AERS recommended POC is developed outlining both waiver and non-waiver services that will meet their individual needs, enable them to avoid institutionalization, and remain as independent as possible in the least restrictive environment.

d) AERS may recommend nursing home services rather than community services if an individual's care needs require a higher level of care and supervision.

The strategies to mitigate risk are incorporated into the POC, subject to participant needs and preferences are as follows:

a) The participant's waiver case manager utilizes the assessments and AERS recommended POC to assist in the development of the POC.

b) Recommending an environmental assessment to determine what physical, cognitive and/or structural issues a participant may have that would put them at risk in their residence, and the supports necessary in order for the participant to live more safely in their residence.

c) Recommending a behavioral consultation assessment by a licensed psychologist, registered nurse, or clinical social worker at a participant's home or facility.

d) Recommending a nutritional consultation assessment by a licensed dietitian or nutritionist to determine what nutritional issues could place the participant at risk.

e) Utilizing the recommendations from the environmental, behavioral, or nutritional assessments in the POC.

f) Recommending a change in waiver services as a result of a change in the participant's health and/or environment that the waiver case manager became aware of during a quarterly visit or information provided by the nurse monitor.

g)Revising the POC to increase or add services that may exceed the current cost neutrality between 101% and 125%.

h) Utilizing as a final effort a non-binding document referred to as a "risk contract" that clearly identifies the nature of the risk, what will be expected of the participant and/or authorized representative, waiver case manager, providers, to reduce or avoid the risk and what consequences the participant can expect if the risk is taken despite the contract. Copies of the contract are maintained by the waiver case manager, participant and/or authorized representative, and provider if appropriate.

i) Informing the participant of the possible consequences of refusing services or a change in services, and the possibility that a refusal of services could lead to disenrollment from the Waiver program.

The POC development process for back-up plans and arrangements includes:

a) Requiring that all waiver POCs include a back-up plan for every waiver participant.
b) Each back-up plan must identify procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that would put the participant at risk.
c) The back-up plan should factor into the POC variables that are unique to the participant (i.e. alcohol, drug dependency, uses a wheel chair, is non-verbal, etc.) and specifying actions or communication procedures that should be implemented when utilizing the back-up plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the POC development process, the waiver case manager provides the participant with an entrance letter that explains the choice of providers, and informs the participant and/or authorized representative that a list of approved waiver providers is available to choose from on the OSA's website, which is updated on amonthly basis. Additionally, the waiver case manager or participant and/or authorized representative may contact the OSA to verify the enrollment status of a provider that may not be listed on the OSA's website. When the participant and/or authorized representative request the service of a specific provider,

they can check the OSA website to confirm the provider's enrollment in the waiver. If the requested provider is not a waiver-approved provider, the AAA may assist that provider in the provider application process, or direct the provider to contact the OSA for enrollment information and/or assistance with the application process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i) through the terms of the Memorandum of Agreement between the SMA and the OSA. DHMH's QCR team conducts annual reviews of a sample of waiver plans of care to assure compliance with the waiver proposal and Medicaid regulations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a)The OSA, the AAAs and the SMA are responsible for monitoring the implementation of the Plan of Care (POC) and

participant health and welfare as follows:

i) The AAA case manager develops the POC to include the waiver and non-waiver services, provider type, provider name, units, frequency, and duration of services, signature of each provider and provides a copy of the POC to each provider listed on the POC.

ii) The AAA case manager is required to incorporate a back-up plan into every waiver participant's POC. Each back-up plan must identify procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that would put the participant at risk. The back-up plan should factor into the POC variables that are unique to the participant (i.e. alcohol, drug dependency, wheelchair bound,etc.)and specifying actions (i.e. notifying emergency contacts,implementing evacuation plan, etc.)that should be followed. The OSA is responsible for reviewing a proportionate sample of POCs which includes reviewing the appropriateness of back-up plans.

(b) The monitoring, follow-up and frequency of methods used are:

(i) AAAs conduct quarterly and annual on-site visits with participants to monitor that services are being provided as identified in the POC and may recommend changes to the POC if the participant's needs have changed. The process for POC development, monitoring, revisions, and case manager responsibilities is the same for participants residing in ALFs as it is for participants living in their own homes.

(ii) For participants residing in Assisted Living Facilities (ALFs), the Assisted Living Manager (ALM) is required by licensure regulations to develop an Assisted Living (AL) Service Plan for each resident, which is based on the comprehensive resident assessment process. A service plan is defined as a written plan developed by the ALM in conjunction with the resident and/or authorized representative, if appropriate, which specifies the services that the ALF will provide to the resident, how and by whom they will be provided . The plan includes details of resident-specific precautions that are needed and the level of monitoring required by ALF staff. The AL Service Plan is an ongoing and evolving document that the ALM must review every six months at a minimum. At any point that there is significant change in the participant's status or needs, the plan must be updated at that time. The delegating registered nurse also reviews the resident's service plan on an ongoing basis and provides input as necessary.

The waiver participant's case manager shares the waiver POC with the ALF staff. Likewise, the case manager receives a copy of the waiver participant's AL Service Plan. During the case manager's quarterly on-site visits, the case manager reviews the waiver POC and AL Service Plan with the ALM. The ALM is responsible for daily monitoring of residents which consists of observation, documentation, and reporting. An ALM is not expected to evaluate a participant's medical condition, unless the ALM is a health care practitioner. The medical condition of the participant is reviewed by the physician and the delegating nurse, whose actions must comply with requirements of the Nurse Practice Act. The ALM is required to inform the case manager immediately any time there is a significant change in the participant's status or needs. If the ALM obtains new information about the waiver participant's needs from the delegating nurse or physician, this is discussed with the case manager during the quarterly visit or more frequently by telephone contact, depending on the situation. The determination for additional or enhanced services involves a dialogue between the case manager, participant and/or authorized representative, delegating nurse, ALM, and other health care practitioners as appropriate. In this case, both the AL Service Plan and the participant's waiver POC would be revised and updated. The coordination between the case manager, participant, ALM and delegating nurse increases accountability as well as the timely identification of problems. While a minimum of quarterly on-site visits is required, case managers will visit on a more frequent basis if there are concerns about the participant's health and safety.

If an ALF resident's status changes significantly, the Assisted Living Assessment must be completed utilizing a uniform data collection instrument that was developed for this purpose. The ALM completes the assessment which measures the resident's ability to perform various tasks, including ADLs, IADLs and self administration of medications. The Assessment also requires a licensed health care practitioner to provide medical information on the resident and sign-off on the entire assessment. The ALM must inform the case manager about changes in the participant's status and that a re-assessment of level of care is indicated. In some cases it will be the case manager or delegating nurse who recommend to the ALM that the re-assessment be conducted. The case manager and OHCQ surveyors will review the resident assessment to determine if it was completed correctly and accurately portrays the resident's health status and functional capabilities.

If the assessment reveals that the resident requires a higher level of assisted living care and this higher level of care is expected to be necessary for a period longer than thirty days, the ALF must be licensed to provide the higher level of care. If the ALF is not licensed to provide the higher level of care, an alternative placement must be arranged for the resident unless the ALM requests and is granted a "resident-specific level of care waiver" from OHCQ. To grant a resident-specific waiver, OHCQ requires that the ALF staff clearly demonstrate the resident's needs can be met without jeopardizing the needs of other residents. The resident-specific waiver will no longer apply if the resident's level of care declines or improves such that a higher or lower level of care than authorized by the resident-specific waiver is appropriate. This determination is made based

on the resident assessment process. Additionally, the resident-specific waiver may be revoked if at any point OHCQ determines that the resident's needs are not being adequately met. If a resident's health or safety is in jeopardy, OHCQ will direct the relocation of the resident to a safe living environment. OHCQ and the case manager will assist WOA waiver participants to locate a setting that will provide the appropriate level of care including nursing facility placement.

Waiver participants residing in ALFs are included in the process of developing and revising their waiver POC. Participants and/or authorized representative indicate their agreement with the POC by signing the document. Case managers inform participants that they have a choice of providers for the services identified on their POC and will provide the names of all enrolled providers approved to provide the service/s that is needed. ALF licensure regulations specify that residents must be included in the development of their AL Service Plan and medical treatment. Case managers and OHCQ surveyors monitor to see that ALF staff consistently involve the participant in making choices regarding his/her care which includes selection of service providers.

(iii) AAA Case Managers review all Reportable Events (RE) forms for indicators that services are not being provided, services need to be modified, and/or the participant's health and welfare are at risk.

1. The OSA monitors the implementation of services by reviewing a proportionate sample of participant records such as POCs, Quarterly Reports, and nurse monitoring reports during annual on-site audits of the AAAs. This includes comparing provider claims to the participant's POC.

2. The OSA monitors the participant's health and welfare by reviewing and following up on all REs on an ongoing basis. The OSA may require a CAP from a provider or AAA to further insure that a similar incident and/or complaint will not reoccur and that the participant's health and welfare are secure.

3. DHMH's QCR team annually conducts a 5% review of a sample of participant records at the AAA by examining the for appropriate documentation, quarterly monitoring as well as a participant interviews for evidence that services were provided and appropriate.

4. The SMA monitors POC implementation on an ongoing basis through an analysis of claims payment reports that summarizes all payments made for each waiver participant by service. The SMA makes this report available to the OSA as a monitoring tool.

(c)Systemic information is obtained by:

1. The OSA compiles monthly summary reports of all events and submits quarterly summary reports to the SMA. The reports include the recommendations for systemic changes to improve waiver quality.

2.The OSA and the SMA review the quarterly RE summary reports in the Waiver Quality Council to make recommendations for program, policy, or procedure changes; and to determine the need and provide for technical assistance or training.

3. The OSA and the DHMH QCR team use standardized audit forms to document their audit findings. These findings are scored and entered into a database for analysis, tracking and trending. These are discussed in the monthly interagency meetings.

b. Monitoring Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The following safeguards are in place:
1. Any POC that lists an AAA as a service provider must be reviewed and approved by the OSA.
2. The case manager, by regulation and grant agreement, is required to review the POC as necessary or at least quarterly to determine the appropriateness and adequacy of the services. This means all services regardless of who the provider is, AAA or otherwise.
3. The OSA, as a part of its annual AAA audit, reviews a sample of participant records to ensure proper procedures are followed in the development of the POC which includes: reviewing recommendations for waiver and non-waiver services identified by AERS, confirming that at least one waiver service is listed, an adequate back up plan is in place, service type, frequency and duration is identified, required signatures are obtained, supervisor review and approval is completed,

as well as review of case notes, quarterly review reports, nurse monitoring reports, and reportable events to make certain that the POC reflects any care issues that are identified in these documents.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1: Number and percent of waiver participants whose plan of care (POC) addresses health and safety risk factors. N= Number of waiver participant POC that addressed health and safety risk factor. D= number of waiver participant POCs reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of waiver participants whose Plan of Care (POC) addresses assessed needs. N= Number of waiver participant POCs addressed assessed needs, D= Number of waiver participants POCs reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM3: Number and percent of waiver participants whose plan of care addresses personal goals. N= Number of waiver participant POC that address personal goals, D= Number of participant POCs reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1: Number and percent of participants whose costs of waiver services are within the waiver cost neutrality limits. N= Number of participants whose POC waiver service costs

are within waiver cost neutrality, D= Number of participant POCs reviewed for cost neutrality.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2:Number and percent of participants whose plan of care had an OSA sign-off when the AAA is also a direct service provider. N= Number of participant POC with AAA as a service provider signed off by OSA, D= Number of reviewed participant POC when AAA is a direct service provider.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

☐ **Continuously and Ongoing**
☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1:Number and percent of participants' plans of care that were updated annually. N= Number of reviewed participant plan of care that were updated annually, D= Number of participant POC that were reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of participants' plans of care that were updated when the waiver participants' needs changed. N= Number of reviewed participant plans of care that were updated when participants' needs changed, D= Number of participant plans of care reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants' services that are provided in accordance with the plan of care (POC), including type, scope, amount, duration and frequency specified in the POC. N= Number of reviewed participant records showing services type, scope, amount, duration and frequency were provided in accordance with participants' plan of care, D= Number of participant records reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who have a signed consent form indicating choice of waiver services versus institutional care, choice of services and choice of providers. N= Number of participants records reviewed contained participant signed consent form, D= Number of participant records reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
To assure that the AAAs are following policies and procedures related to Plans of Care (POCs) the OSA reviews a proportionate sample of participant records. The OSA staff review initial, revised, and annual POCs to assure that the records are accurate and complete based on established guidelines and COMAR regulations. The records reviewed include but are not limited to essential participant information, the Adult Evaluation and Review Services (AERS) Comprehensive Health Assessment, required signatures, start and stop dates for services, back-up plans, pre-authorization forms when required, the signed and dated Freedom of Choice Form, signed acknowledgement receipt of waiver welcome packet, list of waiver enrolled providers, and the reportble event policy.
On an ongoing basis the OSA also performs a similar review of POCs that were developed by AAAs that are also enrolled as a waiver service provider by completing a POC monitoring form that is sent to the AAA with the results of the review and possible corrective action.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The OSA addresses any POC deficiency that is identified during the on-site audit of the AAA, and as part of the on-site audit exit interview, the OSA will request a corrective action plan from the AAA. The AAA should revise the POC to correct the deficiency and report back to the OSA. Any non-compliance area that may have an impact on the health, safety, and/or welfare on the participant is corrected immediately

Common deficiencies across AAAs are addressed at case management trainings.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are

available to CMS upon request through the operating or Medicaid agency.

Individuals are informed about the Fair Hearing process during entrance to the waiver in the information provided in the welcome packet. The opportunity to request a Fair Hearing is provided to individuals who:
(a) Are not given the choice between home and community-based services as an alternative to institutional care,
(b) Are denied either a provider(s) or service(s) of their choice,
(c) Have services denied, suspended, reduced or terminated,
(d) Are denied waiver eligibility for medical, technical and/or financial reasons.

When an adverse decision has been made by the OSA, the SMA or their agents, written notice is provided to the individual and their representative. The entity responsible for issuing the adverse action notice varies according to the type of adverse action. The SMA is responsible for all notices regarding waiver eligibility. The notice states what the decision is, reason for the decision and provides detailed information about steps for the individual/representative to follow as well as time frames to request an appeal. If the adverse action involves the reduction, elimination or denial of service/s, the case manager issues a standardized form which includes the same fair hearing rights and instructions used by the SMA for eligibility notices.
The notice to applicants/participants is consistent with the requirements under 42 CFR Part 431, Subpart E.

Both types of notices referenced above provide information to the individual and their representative regarding procedures to follow to assure continuance of benefits while the appeal process is underway.

Notices of adverse actions are maintained by the SMA if the action impacts waiver eligibility. For actions impacting services, the case manager maintains the documentation in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The SMA and the OSA jointly oversee the operation of the complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Participants and their representatives may lodge grievences/complaints through the appeals process, through the SMA's Quality Care Team on-site review, on-site visits by case managers, providers, or grievances and complaints can be made directly to the AAA, the OSA or the SMA. Administrative or quality of care issues such as: access to service; communication issues, service delays, issues with providers' care and/or professionalism are reported through the Reportable Events(RE)policy which will be described more thoroughly in Appendix G.

(b) The Fair Hearing notice informs the appellant about the time frames and process for grievances/complaints registered through an appeal. If a participant appeals within 10 days of the notice of adverse action or before the adverse action is scheduled to occur, Medicaid benefits will continue until there is a final disposition. If the participant does not make a timely appeal within 10 days of the notice, the participant has 30 days total to file an appeal. Grievances/complaints registered through QCRT participant surveys are referred for remediation by informing the case manager/AAA or if the complaint involves the AAA, it will be reported to the OSA and/or the SMA. The process and timelines for addressing complaints is the same as other reportable events described in section G-1.

(c) Grievances/complaints registered through the appeals process are resolved through the Fair Hearing process. The case manager/AAA is responsible for resolving grievances/complaints that are not reported through the RE Policies and Procedures identified through surveys, on-site visits, or through other contacts are responsible for resolving the problem directly with the participant and other appropriate parties. In some cases, the case manager will file a RE based on information or events the participant or provider has shared, so that there is a more formal response especially if the complaint or grievance falls into one of the categories that is required to be reported. Mechanisms used to resolve complaints in the Reportable Event system are described in section G-1. The RE process is not a substitute for the Fair Hearing process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Effective August 1, 2005 DHMH implemented an incident reporting policy called the Reportable Event Policy. The Reportable Event Policy provides a process to ensure the health, safety, and welfare of participants in the Home and Community-Based Services (HCBS) waivers by formalizing a process to identify, report, and resolve Reportable Events (i.e., incidents or complaints) involving HCBS participants in a timely manner.

Under the Reportable Event Policy, reportable events are defined as the allegation or actual occurrence of an incident that adversely and/or has potential to negatively affect the health, safety, and welfare of an individual, as well as, quality of care or service issue complaints. Reportable events may include an allegation of or actual occurrence of any of the following: abandonment, abuse (physical, sexual, emotional, verbal), accident/injury, hospitalization, inpatient psychiatric hospitalization, emergency room visit, death, exploitation, missing person/elopement, neglect (nutritional, environmental, medical, self-

neglect), treatment error, rights violation, use of restraint (physical, chemical, involuntary seclusion), paramedic intervention, suicide, suicide attempt, treatment error, quality of care/service issue, events involving police/fire department, infectious diseases and any other incidents or complaints not specified above.

Entities that are required to report the event and time frame- All entities associated with the Home and Community Based Service Waivers and supports are required to follow reportable event policy and procedure. Reporting entities include case managers, Operating State Agencies, providers (i.e., assisted living facilities, personal/attendant care agencies, self-employed providers, and environmental accessible adaptations providers), waiver participants, and family members of waiver participants.

Reporting entities are required to submit a written report to the case manager and/or operating State agency within 7 calendar days or sooner if the situation warrants. The case manager and/or Operating State Agency will review the event report, perform necessary follow-up action to protect the participant from harm, and determine the appropriate interventions to prevent reoccurrences. Interventions and follow-up action plans must be completed within 7 calendar days of receipt of the original reportable event. Final resolution for all the reported events must occur within 45 calendar days of initial report.

Reporting and follow up action for alleged abuse, neglect and exploitation: Any person who believes that an individual has been subjected to abuse, neglect, or exploitation in the community or an assisted living facility is required to report the alleged incident immediately to the Adult Protective Services and within 24 hours to law enforcement and the OSA.

Immediate Jeopardy is defined as an incident that presents an immediate and serious threat of injury, harm, impairment, or death of an individual. In cases of Immediate Jeopardy, the case manager must submit the report immediately. Unless the reported information regarding the incident is sufficient to determine the conditions are not present and ongoing,the case manager/OSA initiates an on-site survey/investigation within 2 working days of the report.

The OSA and the SMA Follow-up: The OSA compiles monthly summary reports of all events and submits quarterly summary reports to the SMA. The reports include the OSA's analysis of the data and any recommendations for systemic changes to improve waiver quality. The SMA and the OSA review the quarterly reports with the Waiver Quality Council to make recommendations for program, policy or procedure changes. The SMA will prepare an annual report containing analysis of the data, review of statewide trends, identification of potential barriers and recommendations for improvements.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The case managers are responsible for providing the newly enrolled participants and their families with the reportable event policy. The reportable event policy is also posted on the SMA and the OSA websites.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Participant's case manager- Reportable events are reported to the participant's case manager by completing the first two pages of the form. In cases of abuse, neglect, and/or exploitation or incidents defined as immediate jeopardy must be reported to the case manager within 24 hours of alleged incident. Additionally, agencies such as APS and law enforcement should be contacted. The case manager will gather information and make sure that the appropriate actions are taken to protect the waiver participant from harm. The case manager reviews and analyzes provider actions, performs all other follow-up actions, summarizes findings, and documents this information on page 3 of the reportable form and forwards it to the OSA within 7 days.

OSA logs the event and reviews the information to determine if further follow up is needed. The event is closed if the documented information or follow- up information requests from the case manager shows a resolution in the matter and that all appropriate actions were taken to protect the participant from harm and all appropriate entities were contacted. For incidents requiring remediation, the OSA will request a Corrective Action Plan (CAP) from the provider or case manager as appropriate.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA and the OSA jointly oversee the implementation of reportable event program. The OSA compiles Monthly Summary Reports (MSR) of all events and submits quarterly summary reports to the SMA based on an agreed format and data elements including recommendations for systemic changes to improve waiver quality. The OSA and the SMA will review the quarterly

reports in the Waiver Quality Council to make specific recommendations for program, policy, or procedure changes and determine the need and provide for technical assistance or training.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  The use of restraints is presently allowed in Maryland's assisted living facilities ALF). The DHMH Office of Health Care Quality (OHCQ) licenses and monitors ALFs. Monitoring includes the use of restraints as part of its standard licensing reviews and complaint investigations. ALF licensing regulations stipulate that physical or chemical restraints may only be used under certain limited circumstances.
  These circumstances include:
  a) when the participant is temporarily a danger to self or others
  b) when a physician determines that the temporary use of restraints is necessary to assist in the treatment of medical conditions

  Safeguards for the use of restraints include:
  a) drugs may not be used in excessive doses, including duplicate drug therapy
  b) drugs may not be used for long duration without close monitoring
  c) drugs may not be used without adequate justification for its use
  d) drugs may not be use ddin the presence of adverse reactions that indicate the drug dosage should be reduced or the drug discontinued
  e) physical restraints require a physicians order that specifies the restraint is necessary to treat the resident's medical condition
  f) physical restraints may not be used for discipline or staff convenience

  Each ALF is required to employ a delegating registered nurse that visits the ALF at least once every 45 days. The delegating nurse has the responsibility to work with the ALF staff to explore alternatives to the use of restraints. The delegating nurse is responsible for communicating with the resident's physician if the restraint orders
  are unclear regarding the reason for their use, if the length of time for use seems excessive or the staff do not fully understand the orders.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

  OHCQ is responsible for assessing the use of restarints in ALFs according to licensing regulations and policy. OHCQ has a licensing unit dedicated to monitoring ALFs that serve waiver participants. The coordinator of the Medicaid Waiver Licensing Unit is in frequent contact with staff of the OSA and SMA when concerns are identified. All surveys and complaint investigations handled by OHCQ are shared with the OSA and SMA.

The oversight is conducted during licensing or complaint investigations which can happen at any time. The AAAs have the most frequent direct observation of waiver
participants. They are resposnible to notify the OSA through the RE process and the OSA will forward a complaint to OHCQ within 24 hours. This can be handled over the phone or on line as OHCQ has a complaint form on line for anyone's use.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  Other than the limited use of restraints in ALFs as previously documented, there are no
  restrictive interventions allowed.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For participants in assisted living, the delegating nurse is responsible for monitoring participant medication

regimens. When a participant cannot administer their own medications, the case manager arranges for the services of a Certified Medication Technician(CMT) to administer medications. The medication technitian work under the supervision of a delegating nurse.

The nurse performs an initial and 45 day assessment during each site visit. At this time, the delegating nurse assesses the competency and performance of the medication technitian who administers and documents the medication administration. The OHCQ reviews a participant's full medication regimen during their periodic inspections, complaint investigation and follow-ups as appropriate.

In addition, COMAR 10.07.14, requires that a licensed pharmacist conduct an on-site review of the ALF residents receiving 9 or more medications(including over the counter and PRN meds) every six months..

For participants living at home, the nurse monitor is responsible for participant medication regimens on a monthly basis during a home visit. At this time, the nurse monitor assesses the competency and performance of the Certified Nursing Assistant (CNA)and Certified Medication Technitian (CMT) who administers and documents the medication administration.

During the QCR Team annual reviews of a sample of waiver participants, team members review the medication administration records and report their findings in a report to the AAA.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

To ensure that the participant's medications are managed appropriately, the SMA's QCR team conducts annual reviews of a sample of waiver participants. Team members review the medication administration records and report their findings in a report to the AAA. Additionally, the case managers are required to conduct quarterly visits with participants which includes reviewing medication administration records. In cases where potentially harmful practices are identified, the case manager should immediately address the issue and complete the reportable event form for submission to the OSA for follow-up.

The OSA is responsible for review and follow-up of the reportable event which may include issuing the corrective action plan to the provider as part of its remediation efforts.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The delegating nurse is responsible for monitoring participant medication regimens. When a participant cannot administer their own medications, the case manager arranges for the services of an individual that is both certified as a nursing assistant and medication technician or is certified as a medication aide. The certified nursing assistant and medication technician, or medication aide work under the supervision of a delegating nurse.

For participants in assisted living, the nurse performs an initial and 45 day assessment during each site visit. At this time, the delegating nurse assesses the competency and performance of the certified medication technician who

administers and documents the medication administration. The OHCQ reviews a participant's full medication regimen during their periodic inspections, complaint investigation and follow-ups as appropriate.

For participants living at home, the nurse monitor is responsible for participant medication regimens on a monthly basis during a home visit. At this time, the nurse monitor assesses the competency and performance of the individual that is both certified as a nursing assistant and medication technician or is certified as a medication aide who administers and documents the medication administration.

During the QCR Team annual reviews of a sample of waiver participants, team members review the medication administration records and report their findings in a report to the AAA.

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors are reported to the OSA and the SMA.

  (b) Specify the types of medication errors that providers are required to *record:*

  Any event that requires medical services beyond first aid is required to be recorded by the provider. This would include any preventable event that may cause or lead to inappropriate medication use or harm, while the medication is in the control of the health care professional, family member, or participant. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling; packaging; nomenclature; compounding; dispensing; distribution; administration; education; and monitoring.

  (c) Specify the types of medication errors that providers must *report* to the State:

  The Reportable Event policy requires any event that requires medical services beyond first aid to be reported. This would include any preventable event that may cause or lead to inappropriate medication use or harm, while the medication is in the control of the health care professional, family member, or participant. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling; packaging; nomenclature; compounding; dispensing; distribution; administration; education; and monitoring.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Medication errors are reported to the SMA and the OSA.

During the QCR Team annual reviews of a sample of waiver participants, team members review the medication administration records and report their findings in a report to the AAA.

DHMH's OHCQ employs a dedicated Medicaid waiver survey unit to license and monitor all assisted living facilities that participate in the Waiver for Older Adults. All OHCQ surveys include a review of medication administration, documentation and staff credentials to ensure appropriate staff is administering medications.

The OSA conducts desk and on-site audits on a monthly basis of providers that administer medications to waiver

participants to verify the credentials of the staff administering medications.

Case manager's conduct on-site quarterly reviews of participant files. Medication records are reviewed for error and trends are reported to the OSA as appropriate. The OSA requires providers with repeat medication errors to submit a Corrective Action Plan. The OSA reports trends to the SMA in their quarterly report as appropriate.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1:Number and percent of participant RE (incidents and complaints) reported in accordance with the RE policy. N= Number of REs reported in accordance with the Re Policy, D= Number of REs reported to OSA.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]

☐ **Other** Specify:

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval = 100
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: Number and percent of participant REs (incidents and complaints) reported within RE required timeline. N= number of REs reported within RE required timeline, D= Number of REs reported to OSA.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
PM3: Number and percent of participant abuse, neglect and exploitation REs (incidents and complaints) that follow-up was conducted in accordance with RE policy. N= Number of participant abuse, neglect and exploitation REs where follow-up was conducted in accordance with RE policy, D= Number of participant abuse, neglect and exploitation REs reported.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval = 95
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM4: Number and percent of participants who received education on how to report the REs at enrollment. N= Number of reviewed participant records that contained signed acknowledgment form that they received a copy of RE policy and fact sheet, D= Number of participant records reviewed by OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The OSA reviews all Reportable Events (REs) submitted to the AAA case managers by providers or participants to make sure there was appropriate intervention and follow-up. Reports of abuse, neglect, exploitation, or an incident that presents an immediate jeopardy to the participant such as a serious threat of injury, harm, impairment or death are reviewed to determine what immediate action was taken by the provider or case manager to address the issue, including:
a) notification one or more of the following agencies or individuals, as appropriate
(police, Adult Protective Services, participant's family or representative);
b) relocation of the participant, and/or
c) any other actions taken to remediate the situation and to ensure the participant's health, welfare and safety needs were met.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The OSA requests a corrective action plan or plans from providers. The plan will include the implementation of appropriate interventions to address the specific event. Additionally, the action plan will include interventions to prevent re-occurrence and monitoring systemically to assure the action plan and interventions are appropriate and effective. Information regarding the issuance of a corrective action plan is entered into the OSA's Reportable Event and Provider Databases if the problem was reported through the Reportable Event process, and a copy of the corrective plan letter is maintained on the OSA's computer network. If the problem was discovered during the OSA's on-site audit of a AAAs participant files, or when conducting a provider desk or on-site audit, the information is entered into the Provider Database, and a copy of the corrective plan letter is maintained on the OSA's computer network.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA along with the OSA are responsible for trending, prioritizing and determining system improvements based on data analysis and remediation information from ongoing quality improvement strategies. The SMA and the OSA staff are trained to ensure all system improvements of the Waiver for Older Adults (WOA) are implemented and are continuously being addressed.

Regular reporting and communication among the SMA and the OSA, providers, the utilization control agent (UCA) and other stakeholders including the Waiver Advisory Committee and Waiver Quality Council facilitates ongoing discovery and remediation. The Office of Health Services is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which also includes data analysis, trending and the formulation of recommendations for system improvements. These partners include, but are not limited to, the Office of Health Care Quality (OHCQ), WOA Providers, participants, family, Waiver Quality Council and the Waiver Advisory Committee. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which may also include stakeholders.

When program data is received, it is documented by the OHS and the OSA staff. Data sources include but are not limited to provider enrollment documents, the OSA provider and participant audits, the OSA provider database, the WOA Tracking System, Quality Care Review (QCR) reviews, reportable event submissions (including quarterly RE reporting) participant and provider appeals and Service Utilization Reports (SURs). Data is disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate databases, spreadsheets and logs for analysis. The data is reviewed by the SMA and the OSA staff noting trends and anomalies that may need immediate attention. Forums such as interagency coordination meetings, waiver advisory Committee meetings or the Waiver Quality Council meetings are utilized to discuss trending topics and recommendations for remediation. Plans developed as a result of this process will be shared with stakeholders for review and recommendations. WOA stakeholders are notified of systemic changes through DHMH transmittals, letters, memos and/or postings on the SMA and the OSA website.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The efficiency of the waiver quality improvement strategy design is an ongoing process performed by the OHS and MDoA Program staff who are responsible for the administration of the waiver, the implementation of program improvement strategies and subsequent assessment of their effectiveness. Data from RE reports are reviewed quarterly and data derived from MDoA provider audits and QCR reviews, provider/participant appeals and Service Utilization Reviews are assessed when they have been completed. The MDoA participant and provider audits and QCR reviews occur annually. Other oversight activities occur at pre-determined intervals. If a system change is needed, the OHS and MDoA design plan and implement the system change. Program staff provide data analysis on the change and its efficiency or effectiveness post implementation. Data post system change will be reported during interagency coordination meetings. Once reviewed and analyzed a report compiling outcomes will be written. Data related to the change will be shared verbally and by written report with the Waiver Quality Council and other stakeholders who are engaged in the formulation of program strategies.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Administering waiver staff continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will flow into the waiver from many sources, such as, Reportable Events, waiver performance measures, case manager quarterly reports, provider licensure, complaint surveys/reports, Fair Hearings and provider audits. If the quality improvement strategy is not working as it should be, the repetition of issues and problems and unsuccessful improvement will indicate that the quality management plan must be reconfigured. To provide structure to the periodic evaluation of the quality improvement strategy, the SMA and the OSA program staff will routinely involve the Waiver Quality Council.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) There are no requirements for the independent audit of providers.
(b) There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.
(c) The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete

the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM1:Number and percent of system edits determined to be functioning during an annual review. N= number of system edits reviewed annually determined to be functioning, D= Total number of system edits reviewed annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of MMIS subsystem.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2 Number and percent of reviewed claims that are submitted by providers prior to the effective date of the plan of care. N = # of paid claims prior to POC begin date D = # of paid claims reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
SURS:
The Surveillance and Utilization Review Subsystem (SURS) is used by the SMA to provide comprehensive profiles of the utilization of services by providers and recipients of the Medicaid Program. These reports are used to assist in the detection of Program fraud and abuse, to monitor quality of service, and provide for the development of Program policy. Over time the SMA has used SURS to review problematic billing in several different service areas.

Currently, the SMA runs SURS reports on a regular basis to detect problem billing by assisted living providers that have waiver participants who receive adult medical day care services. The SMA has made numerous recoveries since implemeneting this SURS report and has observed a reduced level of non-compliant billing.

ALL SERVICES REPORT:
The SMA provides the OSA with an All Services Report that provides Medicaid paid claim data for all waiver participants during the report period. The OSA uses this information when auditing the AAAs. Additionally, the OSA shares the report data pertinent to each AAA with the AAA so they can perform utilization review and monitor for non-compliant billing.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
PM1 If edits are not functioning, the SMA program WOA Waiver Coordinator meets with appropriate staff in the SMA Office of Systems, Operations and Pharmacy (OSOP)to determine the nature of the problem with the edit. If the problem can't be immediately remediated, OSOP staff will request the Waiver Coordinator to iniiate the necessary forms to document the nature and function of the edit. If there is a delay in OSOP staff fixing the edit, the waiver coordinator will review paid claim data for claims submitted during the period the edit was not functional. Reimbursement that was made for claims not in accordance with program policy, will be recovered by the SMA.

PM2 The SMA routinely initiates a recovery of funds paid to a provider for services provided in excess or not in accordance with, the participant's approved plan of care. Providers are required to submit a plan of correction and receive technical assistance from the OSA and/or the SMA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate. The primary general method for problem correction in this area is provider group training by the OSA on Medicaid waiver billing. Additionally, the SMA distributes Billing Instruction Guidelines to all providers and updates them as necessary to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate Determination Methods
The SMA is responsible for establishing provider rates. According to COMAR 10.09.54, WOA providers will be paid the lesser of their usual and customary charge to the general public or the Program's rate which is established according to a methodology specified in the aforementioned chapter of regulations. Under this methodology, services with the exception of environmental modifications, assistive equipment and personal emergency response systems automatically increase on July 1 of each year subject to the limitations of the State budget, by the lesser of:

(a) 2.5 percent; or

(b) The change from March to March in the medical care component of the Consumer Price Index for all urban consumers (CPI-U) for the Washington-Baltimore area.

If changes are necessary to any part of the reimbursement methodology, such as in the case of cost containment adjustments to rates, the regulations are amended. Amended regulations are published in the Maryland register with a public comment period. Additionally, all proposals to amend waiver regulations are discussed in advance with the Waiver Advisory Committee.

Rates are not uniform for every provider of a service. Rates may vary due to complexity of the level of care provided, or based on whether an agency or self-employed individual provides the care or based on the setting in which services are rendered.

Following are examples:

Assisted Living Services
Residents in ALFs are assessed as requiring one of three levels of service. Level I is the least complex or involved level of service and Level III is the most complex. The WOA reimburses for the care of participants at either Level II or Level III because these levels reflect the type of services and supports that someone with a nursing facility level of care would typically require to be safely maintained in the community. Medicaid reimburses ALF providers at a higher rate for Level III services than Level II services to reflect the higher cost of rendering a more complex level of care and services.

Additionally, ALFs who send individuals to medical day care will have their daily rate reduced by approximately 25% because services are duplicative to some degree. The 25% reduction in the rate is based upon our estimate of reduced workload and costs incurred by assisted living facilities when a residnet is away from the facility for an average of 6 hours per day receiving health services and meals. The rate reduction was determined to be reasonable enough to deter unnecessary utilization of services, but not so drastic as to prevent individuals from receiving medical day care services. Therefore, there are four rates for assisted living services: daily rate for assisted living level II, daily rate for assisted living level II and medical day care services, daily rate for assisted living level III, and daily rate for assisted living level III and medical day care services.

Personal Care and Respite Care
Personal care hourly reimbursement rates are higher for agency providers than for self-employed workers. The same is true for respite care. A higher hourly rate is paid for these services when provided by an agency or a nursing facility to compensate for some of the agency's administrative overhead costs.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Flow of Billings
Waiver providers submit all claims, paper or electronic, to the OSA or to certain AAA's that have been trained by the OSA and approved by the OSA and the SMA to process waiver claims at the local level. After the OSA or the AAA reviews the waiver claims for completeness, attachment of time sheets, etc, the claims are forwarded electronically to the SMA's MMIS. Payments are issued directly to providers after claims have been processed through MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).

(Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the approved Medicaid Management Information Systems (MMIS). The majority of claims are processed by the OSA with a small percentage processed by the designated AAAs prior to submission to MMIS.
a) MMIS automatically checks for the participant's waiver eligibility on the date of service billed. The system is edited to reject any claim submitted for services to participants who are not Medicaid eligible at the time service/s was rendered. The claim is also edited for any service limitations that are specified in the WOA program regulations, such as meal service claims will be denied if the participant is coded as residing in an ALF.

b)The OSA billing procedures require that claims for services may only be entered by staff into the billing software for services that have been authorized in a participant's Plan of Care (POC). The AAAs that processs local claims are trained in these procedures. POCs are included in the Medicaid Waiver for Older Adult Tracking System and the OSA billing staff have access to the Tracking System. The face sheet of the view version of a POC in the tracking system indicates whether the POC has final approval. An approved POC is the only document used when billing staff enter or change the waiver service(s) information required by the billing software.

Unusual patterns in billing are reported to the AAA Waiver Coordinator, the OSA Billing Manager and/or the Waiver Manager for follow-up.

c)Claim forms are reviewed to ensure the following are correctly completed:

1. The field requesting participant's name, address and Medicaid number;
2. The fields on the form for date of service, type of service, procedure code, charges, and units of service;
3. The signature section of the claims form has an original provider signature. A copy of the signature is not accepted;
4. The provider's name, business name, address and phone number.
5. The provider's 10 digit provider number (9 digit Waiver provider number with a "5" in front for the atypical provider designation).

Time sheets and/or claim forms with discrepancies are attached to a completed correction cover sheet and returned to the provider for correction.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Several of the area agencies on aging provide home delivered meals. AAAs may alos provide transition services for individuals leaving nursing homes.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and**

returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated

with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The assisted living program rates are calculated excluding room and board. There is a uniform room and board charge established for the waiver that is the responsibility of the participant.
This charge is currently $420 per month and is paid directly by the participant to the assisted living manager.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☑ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded.

The only waiver service for which there is a co-pay assessed is assisted living. If a participant chooses assisted living services, the SMA eligibility staff calculate the individual's co-payment amount based on their income. Individuals who receive SSI are not assessed a co-payment.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

- ◉ **There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
- ○ **There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver**

participant.

Specify the cumulative maximum and the time period to which the maximum applies:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	28181.22	3481.00	31662.22	55103.58	4788.63	59892.21	28229.99
2	32269.99	3690.00	35959.99	57134.00	4884.41	62018.41	26058.42
3	34334.56	3911.00	38245.56	59411.94	4982.09	64394.03	26148.47
4	34640.33	4146.00	38786.33	61563.81	5081.74	66645.55	27859.22
5	35918.60	4395.00	40313.60	63976.25	5183.37	69159.62	28846.02

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will

be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	3750	3750
Year 2	3750	3750
Year 3	3750	3750
Year 4	3750	3750
Year 5	3750	3750

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (LOS)for Waiver Years 1 through 5 is determined by averaging the length of stay data from FY's 08,09 & 10 372 reports. We project the average LOS will be 303 days in WY1, 308 days in WY2, 314 days in WY3, 319 days in WY4, and 325 days in WY5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For most covered waiver services, the users and utilization numbers have increased by 1.0% for WY's 1-5. This is based upon a combination of FY'10 372 actual calculations and 3 year averages from FY's 08, 09, and 10. For services that have either higher or lower users or utilization, the percent increases vary based upon trending patterns.

User and utilization projections for Respite Care with Medication Administration for Agency and Personal Care providers are based upon 3 year trending averages for existing respite services that do not currently include medication administration.

A.12: projections are based upon FY'10 actual calculations and the 3 year trending average and increased needs of the population.
A.14 projections are based upon FY'10 actual calculations and trending based upon the increased needs of the population.
A.18 projections are based upon the 3 year average for this service and the need for increased training for this service regarding utilization.
A.21 projections are based upon FY'10 actual calculations and trending which suggest more utilization for this service and more participants served on the waiver.
A.23 projections are based upon the 3 year utilization average for this service and trending which suggest more utilization for this service and more participants served on the waiver.
A.29 projections are based upon FY'10 calculations. This service was added as an amendment to the existing WOA

application It is expected that this service will experience increased utilization.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was determined by the average non-waiver cost for FY's 8,9 & 10 372 reports. Based on historical trends, it was determined that D' increased on average 6.0% per year. This percentage was added to WY's 2 through 5.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

We derived Factor G from the average daily rate (cost divided by bed days) of nursing home care for all individuals age 50 and above. We multiplied the average daily rate by the average length of stay projected for each year of the renewal. The daily rate was inflated annually by the predicted average yearly increase in cost of 2% based on the Consumer Price index for medical care in the Washington-Baltimore area.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Using the same individuals identified in Factor G, we derived Factor G' by calculating the average cost of all non-nursing home services delivered to these individuals. The daily rate was inflated annually by the predicted average yearly increase in cost of 2% based on the Consumer Price index for medical care in the Washington-Baltimore area.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Medical Day care
Personal Care
Respite
Assisted Living
Assistive Devices and Equipment
Behavior Consultation Services
Dietitian/Nutritionist Services
Environmental Accessibility Adaptations
Environmental Assessments
Family/consumer Training
Home-Deliverd Meals
Personal Emergency Response Systems (PERS)
Senior Center Plus
Transition Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to

populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day care Total:						**13411621.44**
Adult Medical Day care	one Day	1176	158.00	72.18	**13411621.44**	
Personal Care Total:						**65805365.50**
Self-Employed Personal Care Aide w/o Medication	one Hour	331	2495.00	10.02	**8274966.90**	
Self-Employed Personal Care Aide with Medication	one Hour	51	2353.00	13.08	**1569639.24**	
Agency Personal Care Aide w/o Medication	one Hour	1380	2238.00	12.81	**39562916.40**	
Agency Personal Care Aide with Medication	one Hour	460	1893.00	16.70	**14542026.00**	
Personal Care Agency Nurse	one Hour	1894	16.00	61.24	**1855816.96**	
Respite Total:						**729488.71**
Respite Care- Self Employed	one Hour	15	153.00	10.02	**22995.90**	
Respite Care- Agency	one Hour	369	99.00	12.81	**467962.11**	
Respite Care- Nursing Facility	one Day	2	45.00	133.60	**12024.00**	
Respite Care -Assisted Living	one Day	33	14.00	71.25	**32917.50**	
Respite Care Services - Agency with Meds	one Hour	70	98.00	16.09	**110377.40**	
Respite Care Services - Self-Employed with Meds	one Hour	70	98.00	12.13	**83211.80**	
Assisted Living Total:						**22911322.23**
Assisted Living Services Level II w/o Medical Day Care	one Day	387	165.00	56.01	**3576518.55**	
Assisted Living Services Level III w/o Medical Day Care	one Day	1296	164.00	70.65	**15016233.60**	
Assisted Living Services Level II w/Medical Day Care	one Day	147	119.00	42.02	**735055.86**	
Assisted Living Services Level III w/Medical Day Care	one Day	559	121.00	52.98	**3583514.22**	
Assistive Devices and Equipment Total:						**325898.26**
Assistive Devices and Equipment	one Service	1202	1.00	271.13	**325898.26**	
Behavior Consultation Services Total:						**119601.72**
Behavior Consultation Services	one Hour	217	9.00	61.24	**119601.72**	
Dietitian/Nutritionist Services Total:						**7655.00**
Dietitian/Nutritionist Services	one Hour	25	5.00	61.24	**7655.00**	
Environmental Accessibility Adaptations Total:						**334408.59**
Environmental Accessibility Adaptations	one Service	111	1.00	3012.69	**334408.59**	
Environmental Assessments Total:						

						50662.30
Environmental Assessments	one Service	130	1.00	389.71	**50662.30**	
Family/consumer Training Total:						**551.16**
Family/consumer Training	one Hour	3	3.00	61.24	**551.16**	
Home-Deliverd Meals Total:						**988317.80**
Home-Deliverd Meals	two Meals	487	365.00	5.56	**988317.80**	
Personal Emergency Response Systems (PERS) Total:						**615585.30**
Personal Emergency Response Systems (PERS)	one Service	213	1.00	71.50	**15229.50**	
Personal Emergency Response System Monitor/Monthly Maintenance	one Month	1123	12.00	44.55	**600355.80**	
Senior Center Plus Total:						**371780.97**
Senior Center Plus	one Day	69	121.00	44.53	**371780.97**	
Transition Services Total:						**7316.45**
Transition Services	one Service	5	1.00	1463.29	**7316.45**	
			GRAND TOTAL:			**105679575.43**
			Total Estimated Unduplicated Participants:			**3750**
			Factor D (Divide total by number of participants):			**28181.22**
			Average Length of Stay on the Waiver:			303

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day care Total:						**15050566.50**
Adult Medical Day care	Daily	1187	158.00	80.25	**15050566.50**	
Personal Care Total:						**75546187.97**
Self-Employed Personal Care Aide w/o Medication	Hourly	335	2495.00	11.39	**9520046.75**	
Self-Employed Personal Care Aide with Medication	Hourly	51	2353.00	14.86	**1783244.58**	
Agency Personal Care Aide w/o Medication	Hourly	1393	2238.00	14.56	**45391295.04**	
Agency Personal Care Aide with						

Medication	Hourly	464	1893.00	18.99	**16679904.48**	
Personal Care Agency Nurse	Hourly	1951	16.00	69.57	**2171697.12**	
Respite Total:						**833344.95**
Respite Care- Self Employed	Hourly	15	153.00	11.39	**26140.05**	
Respite Care- Agency	Daily	387	99.00	14.56	**557837.28**	
Respite Care- Nursing Facility	Daily	2	45.00	151.79	**13661.10**	
Respite Care -Assisted Living	Daily	33	14.00	80.96	**37403.52**	
Respite Care Services - Agency with Meds	Hourly	71	98.00	16.25	**113067.50**	
Respite Care Services - Self-Employed with Meds	Hourly	71	98.00	12.25	**85235.50**	
Assisted Living Total:						**26342643.37**
Assisted Living Services Level II w/o Medical Day Care	Daily	391	165.00	63.62	**4104444.30**	
Assisted Living Services Level III w/o Medical Day Care	Daily	1309	164.00	80.24	**17225602.24**	
Assisted Living Services Level II w/Medical Day Care	Daily	149	119.00	47.73	**846300.63**	
Assisted Living Services Level III w/Medical Day Care	Daily	564	121.00	61.05	**4166296.20**	
Assistive Devices and Equipment Total:						**366219.78**
Assistive Devices and Equipment	Service	1262	1.00	290.19	**366219.78**	
Behavior Consultation Services Total:						**137122.47**
Behavior Consultation Services	Hourly	219	9.00	69.57	**137122.47**	
Dietitian/Nutritionist Services Total:						**8696.25**
Dietitian/Nutritionist Services	Hourly	25	5.00	69.57	**8696.25**	
Environmental Accessibility Adaptations Total:						**361138.40**
Environmental Accessibility Adaptations	Service	112	1.00	3224.45	**361138.40**	
Environmental Assessments Total:						**58443.00**
Environmental Assessments	Service	132	1.00	442.75	**58443.00**	
Family/consumer Training Total:						**626.13**
Family/consumer Training	Hourly	3	3.00	69.57	**626.13**	
Home-Deliverd Meals Total:						**1182950.40**
Home-Deliverd Meals	Meal	512	365.00	6.33	**1182950.40**	
Personal Emergency Response Systems (PERS) Total:						**659838.04**
Personal Emergency Response Systems (PERS)	Service	215	1.00	76.52	**16451.80**	
Personal Emergency Response System Monitor/Monthly Maintenance	Monthly	1134	12.00	47.28	**643386.24**	

Senior Center Plus Total:						**426466.92**
Senior Center Plus	Daily	69	121.00	51.08	**426466.92**	
Transition Services Total:						**38206.25**
Transition Services	Service	5	5.00	1528.25	**38206.25**	
			GRAND TOTAL:			**121012450.43**
			Total Estimated Unduplicated Participants:			**3750**
			Factor D (Divide total by number of participants):			**32269.99**
			Average Length of Stay on the Waiver:			308

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day care Total:						**15583498.92**
Adult Medical Day care	Daily	1199	158.00	82.26	**15583498.92**	
Personal Care Total:						**78273549.99**
Self-Employed Personal Care Aide w/o Medication	Hourly	338	2495.00	11.68	**9849860.80**	
Self-Employed Personal Care Aide with Medication	Hourly	52	2353.00	15.23	**1863481.88**	
Agency Personal Care Aide w/o Medication	Hourly	1407	2238.00	14.92	**46981080.72**	
Agency Personal Care Aide with Medication	Hourly	469	1893.00	19.47	**17285796.99**	
Personal Care Agency Nurse	Hourly	2010	16.00	71.31	**2293329.60**	
Respite Total:						**881916.24**
Respite Care- Self Employed	Hourly	15	153.00	11.68	**26805.60**	
Respite Care- Agency	Daily	406	99.00	14.92	**599694.48**	
Respite Care- Nursing Facility	Daily	2	45.00	155.59	**14003.10**	
Respite Care -Assisted Living	Daily	33	14.00	82.99	**38341.38**	
Respite Care Services - Agency with Meds	Hourly	72	98.00	16.41	**115788.96**	
Respite Care Services - Self-Employed with Meds	Hourly	72	98.00	12.37	**87282.72**	
Assisted Living Total:						

						27271884.35
Assisted Living Services Level II w/o Medical Day Care	Daily	395	165.00	65.21	**4250061.75**	
Assisted Living Services Level III w/o Medical Day Care	Daily	1322	164.00	82.25	**17832458.00**	
Assisted Living Services Level II w/Medical Day Care	Daily	150	119.00	48.92	**873222.00**	
Assisted Living Services Level III w/Medical Day Care	Daily	570	121.00	62.58	**4316142.60**	
Assistive Devices and Equipment Total:						**394108.00**
Assistive Devices and Equipment	Service	1325	1.00	297.44	**394108.00**	
Behavior Consultation Services Total:						**142477.38**
Behavior Consultation Services	Hourly	222	9.00	71.31	**142477.38**	
Dietitian/Nutritionist Services Total:						**8913.75**
Dietitian/Nutritionist Services	Hourly	25	5.00	71.31	**8913.75**	
Environmental Accessibility Adaptations Total:						**3734656.78**
Environmental Accessibility Adaptations	Service	113	1.00	33050.06	**3734656.78**	
Environmental Assessments Total:						**60358.06**
Environmental Assessments	Service	133	1.00	453.82	**60358.06**	
Family/consumer Training Total:						**641.79**
Family/consumer Training	Hourly	3	3.00	71.31	**641.79**	
Home-Deliverd Meals Total:						**1272072.45**
Home-Deliverd Meals	Meal	537	365.00	6.49	**1272072.45**	
Personal Emergency Response Systems (PERS) Total:						**683441.23**
Personal Emergency Response Systems (PERS)	Service	217	1.00	78.43	**17019.31**	
Personal Emergency Response System Monitor/Monthly Maintenance	Monthly	1146	12.00	48.46	**666421.92**	
Senior Center Plus Total:						**439254.20**
Senior Center Plus	Daily	70	121.00	51.86	**439254.20**	
Transition Services Total:						**7832.30**
Transition Services	Service	5	1.00	1566.46	**7832.30**	
				GRAND TOTAL:		**128754605.44**
				Total Estimated Unduplicated Participants:		**3750**
				Factor D (Divide total by number of participants):		**34334.56**
				Average Length of Stay on the Waiver:		314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day care Total:						**16133620.16**
Adult Medical Day care	Daily	1211	158.00	84.32	**16133620.16**	
Personal Care Total:						**81034774.06**
Self-Employed Personal Care Aide w/o Medication	Hourly	341	2495.00	11.97	**10184016.15**	
Self-Employed Personal Care Aide with Medication	Hourly	52	2353.00	15.61	**1909977.16**	
Agency Personal Care Aide w/o Medication	Hourly	1421	2238.00	15.30	**48657029.40**	
Agency Personal Care Aide with Medication	Hourly	473	1893.00	19.95	**17863010.55**	
Personal Care Agency Nurse	Hourly	2070	16.00	73.09	**2420740.80**	
Respite Total:						**938816.46**
Respite Care- Self Employed	Hourly	16	153.00	11.97	**29302.56**	
Respite Care- Agency	Daily	427	99.00	15.30	**646776.90**	
Respite Care- Nursing Facility	Daily	2	45.00	159.48	**14353.20**	
Respite Care -Assisted Living	Daily	34	14.00	85.06	**40488.56**	
Respite Care Services - Agency with Meds	Hourly	73	98.00	16.57	**118541.78**	
Respite Care Services - Self-Employed with Meds	Hourly	73	98.00	12.49	**89353.46**	
Assisted Living Total:						**28234287.16**
Assisted Living Services Level II w/o Medical Day Care	Daily	399	165.00	66.84	**4400411.40**	
Assisted Living Services Level III w/o Medical Day Care	Daily	1335	164.00	84.30	**18456642.00**	
Assisted Living Services Level II w/Medical Day Care	Daily	152	119.00	50.14	**906932.32**	
Assisted Living Services Level III w/Medical Day Care	Daily	576	121.00	64.14	**4470301.44**	
Assistive Devices and Equipment Total:						**424392.96**
Assistive Devices and Equipment	Service	1392	1.00	304.88	**424392.96**	
Behavior Consultation Services Total:						**147349.44**
Behavior Consultation Services	Hourly	224	9.00	73.09	**147349.44**	
Dietitian/Nutritionist Services Total:						**9136.25**
Dietitian/Nutritionist Services	Hourly	25	5.00	73.09	**9136.25**	

Environmental Accessibility Adaptations Total:						**386196.66**
Environmental Accessibility Adaptations	Service	114	1.00	3387.69	**386196.66**	
Environmental Assessments Total:						**62332.78**
Environmental Assessments	Service	134	1.00	465.17	**62332.78**	
Family/consumer Training Total:						**657.81**
Family/consumer Training	Hourly	3	3.00	73.09	**657.81**	
Home-Deliverd Meals Total:						**1357717.20**
Home-Deliverd Meals	Meal	564	362.00	6.65	**1357717.20**	
Personal Emergency Response Systems (PERS) Total:						**707304.08**
Personal Emergency Response Systems (PERS)	Service	220	1.00	80.39	**17685.80**	
Personal Emergency Response System Monitor/Monthly Maintenance	Monthly	1157	12.00	49.67	**689618.28**	
Senior Center Plus Total:						**456611.65**
Senior Center Plus	Daily	71	121.00	53.15	**456611.65**	
Transition Services Total:						**8028.10**
Transition Services	Service	5	1.00	1605.62	**8028.10**	
			GRAND TOTAL:			**129901224.77**
			Total Estimated Unduplicated Participants:			**3750**
			Factor D (Divide total by number of participants):			**34640.33**
			Average Length of Stay on the Waiver:			319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Medical Day care Total:						**16699282.28**
Adult Medical Day care	Daily	1223	158.00	86.42	**16699282.28**	
Personal Care Total:						**84008870.83**
Self-Employed Personal Care Aide w/o Medication	Hourly	345	2495.00	12.27	**10561709.25**	
Self-Employed Personal Care Aide						

with Medication	Hourly	53	2353.00	16.00	**1995344.00**	
Agency Personal Care Aide w/o Medication	Hourly	1436	2238.00	15.68	**50391882.24**	
Agency Personal Care Aide with Medication	Hourly	478	1893.00	20.45	**18504264.30**	
Personal Care Agency Nurse	Hourly	2132	16.00	74.92	**2555671.04**	
Respite Total:						**994608.88**
Respite Care- Self Employed	Hourly	16	153.00	12.27	**30036.96**	
Respite Care- Agency	Daily	448	99.00	15.68	**695439.36**	
Respite Care- Nursing Facility	Daily	2	45.00	163.46	**14711.40**	
Respite Care -Assisted Living	Daily	34	14.00	87.19	**41502.44**	
Respite Care Services - Agency with Meds	Hourly	74	98.00	16.74	**121398.48**	
Respite Care Services - Self-Employed with Meds	Hourly	74	98.00	12.62	**91520.24**	
Assisted Living Total:						**29238661.51**
Assisted Living Services Level II w/o Medical Day Care	Daily	403	165.00	68.51	**4555572.45**	
Assisted Living Services Level III w/o Medical Day Care	Daily	1349	164.00	86.41	**19117002.76**	
Assisted Living Services Level II w/Medical Day Care	Daily	153	119.00	51.40	**935839.80**	
Assisted Living Services Level III w/Medical Day Care	Daily	582	121.00	65.75	**4630246.50**	
Assistive Devices and Equipment Total:						**456562.50**
Assistive Devices and Equipment	Service	1461	1.00	312.50	**456562.50**	
Behavior Consultation Services Total:						**152387.28**
Behavior Consultation Services	Hourly	226	9.00	74.92	**152387.28**	
Dietitian/Nutritionist Services Total:						**9739.60**
Dietitian/Nutritionist Services	Hourly	26	5.00	74.92	**9739.60**	
Environmental Accessibility Adaptations Total:						**399323.70**
Environmental Accessibility Adaptations	Service	115	1.00	3472.38	**399323.70**	
Environmental Assessments Total:						**64844.80**
Environmental Assessments	Service	136	1.00	476.80	**64844.80**	
Family/consumer Training Total:						**674.28**
Family/consumer Training	Hourly	3	3.00	74.92	**674.28**	
Home-Deliverd Meals Total:						**1459410.24**
Home-Deliverd Meals	Meal	592	362.00	6.81	**1459410.24**	
Personal Emergency Response Systems (PERS) Total:						**732458.28**

Personal Emergency Response Systems (PERS)	Service	222	1.00	82.40	**18292.80**	
Personal Emergency Response System Monitor/Monthly Maintenance	Monthly	1169	12.00	50.91	**714165.48**	
Senior Center Plus Total:						**468037.68**
Senior Center Plus	Daily	71	121.00	54.48	**468037.68**	
Transition Services Total:						**9874.56**
Transition Services	Service	6	1.00	1645.76	**9874.56**	
			GRAND TOTAL:			**134694736.42**
			Total Estimated Unduplicated Participants:			**3750**
			Factor D (Divide total by number of participants):			**35918.60**
			Average Length of Stay on the Waiver:			325